A study of the relationship between hospital policy and nursing practice

by

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Glossary of Abbreviations and Terms

Abbreviation	Term	Explanation
ACHS	Australian Council on Healthcare Standards	An accreditation body approved by the Australian Commission on Safety and Quality in Healthcare to assess health service organisations against national standards.
ACSQHC	Australian Commission on Safety and Quality in Healthcare	An independent regulatory body in Australia that defines standards for health service organisations and accredits bodies to undertake assessments against those standards.
AE	Adverse event	Any untoward clinical event occurring in a patient that is not directly related to the natural course of their disease process.
AHHA	Australian Hospitals and Healthcare Association	A peak body for public and not-for-profit hospitals and healthcare providers in Australia.
AHPRA	Australian Health Practitioner Registration Authority	The national organisation in Australia responsible for implementing the National Registration and Accreditation Scheme across hospitals. It works with 15 national health practitioner boards, including the Nursing and Midwifery Board of Australia, to implement the scheme.
AHRQ	Agency for Health Care Research and Quality	The lead federal agency in the United States (US) responsible for improving the safety and quality of the US healthcare system. The agency develops knowledge, tools and data required to improve the healthcare system and assist the public, healthcare professionals and policymakers to make informed decisions.
AIHW	Australian Institute of Health and Welfare	Australia's leading health and welfare statistics agency holds data on a wide range of health and welfare issues and topics used by governments, researchers, policymakers and the community.
AMI	Acute myocardial infarction	A life-threatening condition that occurs when blood flow to the heart muscle is reduced, causing damage to the tissues of the heart. AMI is a clinical indicator that is monitored by the ACSQHC and other bodies.

Abbreviation	Term	Explanation
APA	American Psychological Association	APA in this thesis refers to a refencing style published by the American Psychological Association.
	Bracketing	A method used to assist in recording preconceptions of the researcher that may affect the interpretive processes during the interview or in the post-interview.
CHBOI	Core hospital-based outcome indicators	CHBOI is an indicator program that uses nationally risk-adjusted data in Australia to support hospitals' ongoing monitoring and review of outcome-based indicators. Significant variance can be a sign of issues that require further detailed review, such as issues related to data quality and consistency, resources, and quality of care.
CINAHL	Cumulative Index of Nursing and Allied Health Literature	A large research database for nursing and allied health research reporting in journals.
CPG	Clinical practice guideline	This document is based on the systematic identification and synthesis of the best available evidence and makes clear recommendations for health professionals to consider when practicing in an Australian healthcare setting. The National Health and Medical Research Council operates an Australian Clinical Practice Guideline portal.
CQC	Care Quality Commission	An independent regulator of health and social care in England.
	Casemix	This term describes a system whereby information about patients and their reason for admission to hospital are assigned to groupings to assist with billing, health service planning and the use of administrative data for comparing patient acuity and clinical outcomes.
CSCF	Clinical Service Capability Framework	A framework used in Queensland public and licensed private hospitals to describe clinical and support services according to their service capability level. For private hospitals, their license to operate is explicitly linked to the CSCF.
	Dynamic risk assessment	A risk assessment process of observing, assessing and analysing one's work environment in order to

Abbreviation	Term	Explanation
		respond to and remove hazards and risks as they arise.
EQuIP	Evaluation and Quality Improvement program	A standards framework used by hospitals undergoing an accreditation assessment by the ACHS before the introduction of the National Safety and Quality in Health Service Standards second edition.
	Frontline	Nursing staff who work at the patients' bedside or who directly deliver nursing care to patients, synonymous with grassroots.
	Grassroots	Nursing staff working at the patient bedside or directly delivering nursing care to patients, synonymous with frontline.
	Grey literature	Materials and literature produced by healthcare organisations and government bodies outside of published peer-reviewed journals and literature, as they were deemed by the researcher to inform the clinical governance context of the study.
HAC	Hospital-acquired complication	A patient complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. (ACSQHC, 2018b, p. 8)
	Heedfulness	The traits of a nurse of staying aware and being mindful in their practice, and routinely preparing for potential challenges and thinking about potential solutions.
HREC	Human Research Ethics Committee	A hospital/service committee that is registered to review research proposals that involve human participants to ensure that they meet the ethical standards and guidelines set out by the National Health and Medical Research Council in Australia.
	Insider–outsider	'Insider' refers to the researcher's position as a team member inside the organisation who has knowledge of many processes and people. At the same time, the researcher is an 'outsider' to the participant teams being studied and does not have complete local knowledge of processes and people at the ward level.

Abbreviation	Term	Explanation
	In situ	The everyday nursing practice that occurs within the workplace.
ISBAR	Identify, Situation, Background, Assessment, Recommendations	A communication tool used in healthcare to assist nurses in ensuring that all relevant information is shared with other healthcare professions. For example, identify who you are and whom you are speaking about, describe the situation you are experiencing with your patient, explain the background relevant to the patient and situation, provide an assessment of what is occurring, and recommend a course of action.
ISO	International Organization for Standardization	An international independent non-government organisation that develops and shares knowledge of voluntary, consensus-based and market-relevant international standards.
JSTOR	Journal storage	A digital library for researchers, scholars and students to access journals, books and other resources.
	Macro	Public health policy and global or national policy at a broad level.
	Meso	Organisation-wide policy, such as Queensland Health and private hospital groups.
	Micro	The level of hospital policy—for example, at the local ward or unit level.
	Narrative	Spoken or written accounts of patient care activities or nursing stories.
NEAF	National Ethics Application Form	An online application form used for human research ethics application, replaced by the Human Research Ethics Application for all research involving human participants.
NHMRC	National Health and Medical Research Council	Australian expert body in health and medical research, and an independent statutory agency within the portfolio of the Federal Minister for Health and Ageing operating under the *National Health and Medical Research Council Act 1992*.
NHS	National Health Service	A health service funded by the British government to provide healthcare as a single payer, tax-payer funded. It was established by the *National Health Service Act 1946* and subsequent legislation.

Abbreviation	Term	Explanation
NICE	National Institute for Health and Care Excellence	A national organisation established in 1999 to create consistent evidence-based guidelines and rationing of treatment across the United Kingdom.
NMBA	Nursing and Midwifery Board of Australia	An Australian board that provides registration for nursing and midwifery practitioners and students, develops standards/code/guidelines, handles notifications/complaints and investigations, assesses overseas-trained practitioners wishing to practice in Australia, and approves accreditation standards and accredited courses of study.
NSQHSS	National Safety and Quality Health Service Standards	Standards developed by the Australian Commission on Safety and Quality in Healthcare in collaboration with the state and federal governments, private sector providers, clinical experts, patients and carers. The key aim of the standards is to protect the public's health and improve the quality of health service provision. Ten standards were initially released in 2011for hospitals to seek accreditation between 2013 and 2018. The standards were revised and the eight standards for the second edition were released in 2018 to enable hospitals to seek accreditation from 2019.
OECD	Organisation for Economic Co-operation and Development	An international organisation that aims to shape better policy to improve people's wellbeing by establishing evidence-based international standards and sharing best-practice experience and data.
OSHA	Occupational Safety and Health Administration	US federal occupational safety and health administration/state agency responsible for the enforcement of OH&S standards in the US.
PIK	Participant Information Kit	Information pack given to potential and actual research participants in this thesis, including researcher reflection consent form and information sheet.
	Pedagogy	The method and practice of teaching.
	Policy	Policy is presented in the thesis with regulator and accreditor definitions and as an emerging analysis of what it means to frontline nurses.

Abbreviation	Term	Explanation
RCA	Root cause analysis	A systematic process for reviewing clinical events, identifying root causes and making recommendations to prevent similar events in the future.
SAC	Severity assessment code	A method used to determine the level of harm and appropriate action to take for an event or incident based on its score. The score is calculated by comparing the consequence of the incident and its likelihood of occurrence. For example, SAC 1 is a catastrophic outcome and SAC 5 is a near miss or negligible outcome.
	Safety I	A way of thinking when things go wrong as a result of failures and malfunctions of components of a system—for example, nurses, procedures and technology.
	Safety II	A way of thinking whereby nurses and researchers try to understand the majority of clinical practice areas where things go right, as well as understand that nurses are constantly adjusting what they do so their practice matches the current conditions.
	System review	These reviews are undertaken by retrospectively examining an incident or event to determine potential errors or gaps in care. They focus on analysis of systems rather than people, with the aim of learning from the event and driving future practice improvement.
WHO	World Health Organization	The WHO began in 1948 as an international organisation that promotes health and safety and serves the vulnerable.

Glossary of Roles

Abbreviation	Role
CN	Clinical Nurse/Level Two Nurse
DOCS	Director of Clinical Services
EN	Enrolled Nurse
GM	General Manager
HC	Hospital Coordinator/After-Hours Nurse Manager
NE	Nurse Educator
NUM	Nurse Unit Manager
QS	Quality and Safety team
QM	Quality Manager
QC	Quality Coordinator
QA	Quality Associate
RN	Registered Nurse
SN	Student Nurse

Abstract

Title—A study of the relationship between hospital policy and nursing practice

Introduction

System reviews and investigations of adverse events and incidents in hospitals consistently identify factors related to failure to adhere to hospital policy as key causes of patient harm. Hospital policies are mandated as an important clinical governance approach to meet practice standards for nurses and hospital management, and to provide regulatory and accreditation requirements that aim to support the safe provision of patient care.

Purpose

This research study was undertaken to explore and gain a greater understanding of the everyday experiences of nurses and how they make sense of the relationship between hospital policy and nursing practice. The aims of this study are to identify issues regarding policy and nursing practice, describe and gain a greater understanding of the problem, and challenge existing assumptions about hospital policy and nursing practice.

Methods

A bi-phase qualitative research methodology was used in this study. The first phase adapted a hermeneutic phenomenological approach using ten semi-structured in-depth interviews to explore nurses' experiences of policy in one private hospital. The second phase used an ethnographic approach to observe six nurses working eight-hour shifts in medical wards in three private hospitals. Observations were undertaken of how they actually experienced hospital policy in their everyday work, followed by a reflective practice session with the researcher to better understand these experiences.

Results

The study's approach enabled the researcher to observe how nurses actually practice in their daily work in relation to policy. The results provided an understanding of nurses' experiences and every day work through thematic analysis across both phases, including policy meaning; practicality and workplace culture; processes; variation or non-adherence; and practice gaps, knowledge and cynicism. Vignettes further emphasised the effect of complexity on nurses' every day work and described their responses to this challenge regarding hospital policy. The analysis showed that there is a problematic relationship between hospital policy and nursing practice, as there is inconsistency between what is expected by regulators, accreditors and managers and how hospital policy is actually enacted and practiced by frontline nurses.

Conclusions

Nurses do not always read hospital policies as expected by regulators, accreditors and managers; however, they fulfil the requirements of the policies and procedures in their everyday work. They do this by using their knowledge, experience, skills and community of practice to resolve uncertainty and ambiguity in complex workplace settings that focus on patients' care needs. Standards of practice along with regulatory and accreditation standards are built upon the notion of nurses reading and following evidence-based policies and procedures. This study challenges the reality of this notion and proposes areas for further research in this area.

Chapter One: Introduction

1.1 Introduction

Patients in hospital experience unintended and preventable harm every day. Errors are inevitable because we have been treating patients with increasing complexity (Dekker, 2014; Tingle, 2017). Data from the United States (US) Institute of Medicine show that between 200,000 and 400,000 patients experience harm every year, and it is the third leading cause of death behind cancer and heart disease (Kiani, 2019). The Quality in Australian Health Care Study (Wilson et al., 1995) reported that nearly 17% of patients experienced harm in their cohort of hospitals, with 50% estimated as preventable harm. Further, Fernholm et al. (2020) and James (2013) reported that 5–8% of all hospital admissions in high-income countries result in preventable harm. This proportion of harm related to hospital admissions has also been well documented in annual quality and safety reports in each state and territory in Australia, with hospital policy being explicitly implicated. For example, the Department of Health New South Wales (NSW) (2017) identified the top contributing factors according to the clinical management root cause analysis (RCA) review committee. To do this, the organisation categorised the factors according to severity assessment codes (SACs), which are used by risk managers to determine the extent of analysis required for an incident, with SAC1 indicating catastrophic severity. The SAC 1 incidents identified contributing factors including planning, communication, and policy and guidelines (ACSQHC, 2006, 2017a, 2017b; Department of Health NSW, 2017).

Nurses and other healthcare professionals provide care to patients with the guidance of policies, procedures, standards, guidelines, work instructions, processes and many other similar documents. These documents generally aim to ensure that evidence-based, or best-practice, care is provided, and that patients receive safe and appropriate care (Cheney & Head, 2010; Kalhor, Azmal, Moosaui, Asagni, & Gharaghieh, 2017; Iedema et al., 2018;). This study takes an explicit

approach to exploring, understanding and describing nursing practice through the lens of the policy space and through the voices of nurses. Healthcare is complex where both nursing practice and policy are concerned (Dekker, 2014). A linear relationship between safe and appropriate care, evidence-based and best-practice policies and nursing practice is not straightforward in this context (Iedema et al., 2018).

This study makes an important contribution to the body of literature relating to patient safety because it helps nurses to explore, understand and describe how policies relate to their nursing practice and how nurses contribute to providing safe and appropriate care to their patients. Initial anecdotal experiences of the researcher, who works as a nurse leading system reviews following adverse clinical events, raises concerns about policy context. For the purpose of this thesis, system reviews refer to clinical care reviews that are undertaken by retrospectively examining an incident or event to determine potential errors or gaps in care. They focus on analysis of systems rather than people, and they aim to learn from the event to improve future practice (Walker et al., 2018). It is incongruent to the researcher that there are so many policies and procedures in place within and across healthcare settings, and that all nurses are required to read, understand and implement them to prevent patient harm in all clinical situations.

The exponential rise in the number of formal rules that are imposed on healthcare practitioners and their practice highlights the difficulty for nurses in keeping up to date with current best or evidence-based practice (Iedema et al., 2018). There is an assumption that nurses can recognise and appreciate their practice in totality or at least have immediate access to policy documents to assist them in delivering quality and safe care to patients within their level of skill and capability. Policy documents should reflect evidence-based practice or best practice, and nurses are expected to have knowledge of related policies. When an incident or adverse clinical event occurs, system reviews consistently identify communication and policy issues in healthcare organisations as the most common contributing factor to patient harm (Queensland Health, 2012b).

1.2 Overview of the Thesis

An overview of this thesis is presented below to orient the reader with the format and structure of the thesis. This thesis examines the relationship between policy and nursing practice in the context of a complex healthcare environment to understand and describe what is happening with policy in the experience of nurses in their everyday work. This study is presented against the backdrop of clinical governance, and quality and safety programs that resonate with the researcher's experience as a senior nursing leader working in healthcare.

The thesis will describe the journey through the research process and tell a story of policy complexity from the perspective of nurses working in three private hospitals in Queensland. This approach acknowledges the unpredictability that exists in understanding and describing the degree and nature of the relationships between the parts and processes of healthcare systems that nurses face in their everyday work.

The thesis format and referencing style follows the requirements of the peak international journal for nursing, the *Journal of Advanced Nursing*, which uses the manual for the *American Psychological Association (APA) 6th edition*. However, the formatting of quotations has been modified to use indented and inverted commas for ease of presentation in the body of the text.

The thesis is presented in eight chapters that follow the progression of the research to realise the research aims identified and described by the researcher. The introduction chapter describes the researcher's background in order to explain the selection of the research topic. The environment in which policy is situated in healthcare is presented, followed by a statement of the problem, aims of the study, scope of the study and significance of the research study. The following chapters provide the literature review, methodology and methods, findings and analysis, discussion and finally the conclusion.

1.3 The Researcher's Perspective

As a regional safety and quality manager and then as a national director of clinical governance in not-for-profit healthcare organisations, the researcher has been involved in the development, implementation and evaluation of hospital policies in collaboration with healthcare organisations' quality and safety teams. The general aim of these organisations is for hospital policies to assist managers and frontline nurses to provide safe and high-quality care. There are also legislated requirements to maintain the currency of particular policies around jurisdictional, NSQHSS and other related accreditation standards. However, hospitals are complex environments and nurses are constantly dealing with changes in patients' clinical situations and changes to their nursing practice. Nurses receive varying educational opportunities and down-time from their frontline clinical duties, and there are different systems for storing, accessing and updating policies and procedures, which makes it difficult to know and understand every policy that relates to their day-to-day work (Davidson, Ray, & Turkel, 2011; Zimmerman, Lindberg, & Plsek, 2008).

Clarity is required as to whether a policy is considered a rule or a directive, a reference or resource document, or a document that only provides guidance for nursing practice and that could vary based on nursing assessments of individual patients' needs. Amalberti, Vincent, Auroy and de Saint Maurice (2006) questioned whether rules are advisory or mandatory, arguing that there is a lack of clarity between rules, which must be rigidly followed, and guidance. The authors questioned whether policy documents allow nurses to use their own assessment and clinical judgement skills or whether they must follow what the document stipulates for nursing practice (Amalberti et al., 2006). This question implies that nurses undertake some form of reflective practice and that this practice is related to nursing experience and knowledge, whereby situated practice is understood through a reflective lens by those directly involved in the practice (Iedema et al., 2018).

As a senior nursing leader in the organisation, the researcher questioned how reflective practice plays out in every day nursing practice and how it relates to patients experiencing good clinical outcomes or poor clinical outcomes and adverse clinical events. The context of healthcare professionals adapting their practice within the complexity of their everyday work has been challenged (Amalberti, Nicklin, & Braithwaite, 2016; Gabay & Lemay, 2010). There is considerable ambiguity in the researcher's mind in attempting to answer these questions, and in the researcher's reflective experiences as a nursing leader who has contributed to the many perspectives involved in understanding the phenomenon. This unresolved ambiguity points to the need for a better understanding of the nature of in-situ practice (in this thesis, 'in-situ practice' refers to the everyday nursing practice occurring in the workplace), as well as nurses' everyday decisions and behaviours, innovations in practice and relationship to policy.

Benner, Hooper-Kyriakidis and Stannard (2011) considered how a person is morally and ethically shaped into becoming a nurse, and how they learn to instantiate the notion of good in every day nursing practice. This means that nurses think about what it means to provide good care to patients in their everyday work. A strong reflective approach raises awareness of policy creating disturbances in thought and challenging nurses' everyday work. Reflection therefore creates a challenge to find a method to explore, understand and describe the relationship between hospital policy and nursing practice. An approach that improves how policy can make better sense to nurses and other stakeholders within a hospital setting, and within the broader clinical risk management of a clinical governance paradigm, can then be exposed and studied.

Managing clinical risk, incidents and adverse events (in this thesis, an 'adverse event' is any untoward clinical event occurring in a patient that is not directly related to the natural cause of their disease process) is an important part of the role of frontline nurses, team leaders, nursing managers and senior nursing leaders. Nurses with different levels of experience and knowledge can undertake various roles in investigations and system reviews following adverse events. They

are also actively involved in planning and discussing mandatory standards, compliance, auditing, reporting and accreditation processes both locally and across healthcare organisations.

Many narratives (in this thesis, 'narratives' are spoken or written accounts of patient care activities and nursing stories presented as data) arose when the researcher was conducting system reviews relating to nursing practice and policy while practicing in the clinical governance role. The anecdotal experience of the researcher, working as a senior nurse leader, is that the relationship between hospital policy and nursing practice, which is articulated by regulators, accreditors and management, does not make sense to frontline nurses during their everyday work. The researcher identified a gap between what nurses are supposed to practice in relation to policy and what actually occurs in everyday nursing practice. During system reviews, nurses confessed to the researcher, working in the clinical governance role, that they only read policy documents if they needed to know how to follow a particular policy related to a clinical skill they had not used for some time (or at all) or if they did not have another experienced nurse to ask.

During system reviews with the researcher prior to undertaking data collection for this study, nurses reported many inconsistencies in the use of language used to describe a hospital policy. For example, the use of the terms 'policy', 'procedure', 'work instruction', 'guideline' and 'protocol' to refer to a document reinforces the need to explore termination of policy. Nurses have long been observed by the researcher, working in a clinical governance role, to be involved in writing and evaluating policies following incidents or as new standards are released by regulatory bodies. Before this research was conducted, nurses had discussed with the researcher, working in a clinical governance role, whether it was possible for every policy to be read or referred to by every nurse. When asked whether it was accurate to state that they rarely read or referred to policies, nurses involved in system reviews agreed that they had not read the relevant policies, but were uncomfortable in publicly acknowledging this for professional and employment reasons. They described that they know that nurses are supposed to read policies, and they often have to sign or complete a form to attest that they have done so. During system

reviews, nurses shared many narratives that showed a similar problem with policy, but they had few solutions from within the context of participating in a system review.

This research sets out to understand the theoretical basis for studying the relationship between hospital policy and nursing practice, and to provide a greater understanding of what nurses think and feel about policies and practice within the policy space. Nursing behaviour associated with policy is complex and affects how policy and nursing practice are articulated and evaluated, and how outcomes are measured. The researcher challenged herself professionally to consider whether nurses attribute meaning to policy as a concept that differs from literal meanings and definitions ascribed by regulators and accreditors, and whether there is capacity for conflict and confusion. The researcher also began to consider that if there are different perspectives on what policy is and what it means to nurses. For example, a guide to practice or a mandated process. Depending on the nurse's way of thinking or mental model, then variation from policy can be seen in various ways, with positive and negative attributes.

As a nurse with a clinical governance and management role, the researcher initially viewed policy variation as a deviation from practice that contributes to an adverse clinical outcome, which is a deficit thinking approach. However, through the process of development as a senior nurse leader in a clinical governance role, the researcher began to feel internally challenged to think further about the phenomenon in different ways. Through reflective processes, the researcher found that when policy and nursing practice are viewed through other lenses, hospital policy may not be as straightforward as initially perceived. This challenged the researcher to undertake this study to explore, understand and describe the phenomenon better, with the ultimate goal of challenging stakeholders in this setting to enter into a different type of narrative about the relationship between hospital policy and nursing practice. It appears that hospital policy is often experienced as an invisible, banal and unacknowledged problem that is normalised in the daily nursing practice of many frontline nurses. Therefore, this thesis provides

an opportunity to bring this problem to the foreground through the narratives of nurses. This forms the basis for establishing the research question and study design.

1.4 Introduction to the Policy Environment in Healthcare

The policy environment in healthcare is situated against a historical and global backdrop that has influenced how policy is structured and embedded within healthcare settings, with a focus on safe and quality care. Florence Nightingale (1859) wrote that:

> "It may seem a strange principle to enunciate, as the very first requirement in a hospital, that it should do the sick no harm". (p. ii)

Nightingale led an approach that is now known as patient safety. She wrote about policy and collecting data on illnesses and death in order to monitor the effects of nursing practice and to prevent harm (McDonald, 2010).

In terms of the international approach to preventing harm, the World Health Organization (WHO) has been a strong advocate, leading the way in patient safety and policy directions in healthcare. There is strong international evidence regarding the role of policy and standards in supporting effective patient safety approaches published by the WHO (2018). The WHO (2015) launched a patient safety program in 2004 and defined patient safety as:

> "freedom from accidental or preventable injuries produced by medical care". (p. 107)

This emphasises that patient safety is increasingly being recognised as an issue of global significance that requires coordinated efforts to lead and advocate for change, to generate and share knowledge and expertise, and to support the implementation of patient safety. The WHO (2018) reported that patient safety is a serious global public health concern and the 14th leading cause of global disease burden, which is comparable with the disease burden of tuberculosis or malaria. In direct patient harm terms, the WHO (2018) reported a 1:300 chance of a patient being harmed during a hospital admission. A core function of the WHO is to articulate ethical and

evidence-based policy options to develop safer systems and improve patient safety. In many countries around the world, the burden of harm and death as a result of adverse events remains unacceptably high. A number of factors contributing to patient harm have been identified, including the:

> "absence of protocols or policies and the failure to implement protocols or policies". (WHO, 2015, p. 13)

In the United Kingdom, as a result of the Mid Staffordshire National Health Service (NHS) Foundation Trust Public Inquiry (2013), patient safety is part of the NHS Improvement Hub. The inquiry reported numerous warning signs that should have alerted the managers governing the system to the developing problems which are reflected in the recommendations. The recommendations focused on fostering a safety culture that privileged patients first, and implementing standards that all staff would understand and comply with, including accountability, transparency and policy compliance with standards, as well as enhanced education, training and support. Following the Mid Staffordshire Inquiry, the National Institute for Health and Care Excellence (NICE) created standards that are policed by the Care Quality Commission (CQC). NICE (2018) developed evidence-based recommendations for health and care in England, which are reflected in the NICE standards and guidelines. These guidelines were developed to help healthcare practitioners improve their quality of care and services. NICE provides a flowchart visualisation for practice areas as a resource for healthcare professionals, as well as a link to supportive implementation guides. These, in turn, link to guidelines and quality standards, which frame a complete quality management system.

Policy initiatives have been described as a way of improving patient safety in the US. However, it has been recognised that improving patient safety in the context of the tension that exists in a complex healthcare environment has technical, social and organisational components (Small & Barach, 2002). The Joint Commission (TJC) is an independent, not-for-profit US

organisation that accredits and certifies healthcare organisations. TJC has developed universal protocols for wrong-site surgery and evidence-based standards across a diverse range of clinical care areas. To further support standardisation and bring evidence into practice, the Agency for Health Care Research and Quality (AHRQ) is operated by the US Department of Health and Human Services and other partners to ensure that healthcare evidence is understood and used in practice. The AHRQ launched clinical decision-making support tools that are standards-based in order to accelerate the implementation of evidence into practice.

Policies and procedures have been described as highly relevant to maintaining safe practice in healthcare in Australia. The Australian Commission on Safety and Quality in Healthcare (ACSQHC) implemented the National Safety and Quality Healthcare Standards (NSQHSS) to contribute to patient safety and clinical governance (ACSQHC, 2014). The NSQHSS has led to mandated policies to meet governance and accreditation requirements that aim to support the safe provision of patient care (ACSQHC, 2012). The role of clinicians (in this thesis, 'clinician' refers to all registered healthcare professionals) is described in the NSQHSS governance standard as being essential to making health systems safer and more effective if staff follow safety and quality procedures. In January 2019, the NSQHSS second edition consolidated the integral role of policies and procedures in the Clinical Governance Standard (ACSQHC, 2018a). This standard describes that the role of managers is to implement and maintain systems, resources, education and training to ensure that clinicians deliver safe, effective and reliable healthcare. When managers consider safety and quality implications in their decision-making processes, the standard suggests that this would lead to safer systems. This approach to clinical governance emphasises the importance of systems and decision-making processes for nurses and managers in their everyday work in terms of nursing care generally and patient safety specifically. The National Model Clinical Governance Framework supports the implementation of the NSQHSS second edition and contains explicit requirements for roles and responsibilities (ACSQHS, 2018b). Therefore, policies and procedures are mandated from a patient safety

perspective, which filters through to the roles and responsibilities of nurses and managers and sets the expected standard to be achieved and maintained. Additionally, the achievement of the national standards is influenced by the practicality of the everyday work of nurses, workloads, resourcing, competing demands on nurses' time, complexity of healthcare in every day practice and many other system and human factors. Therefore, clinical governance is an approach that aims to integrate the various components of the healthcare system to support safe and high-quality provision of patient care.

Clinical governance in the NSQHSS has been described as a:

> "system through which organisations were accountable for continuously improving the quality of their services and safeguarding high standards of care" (ACSQHC, 2012, p. 7),

supporting a systems-based approach. Systems thinking has developed alongside patient safety initiatives and reflects continuous improvement in the approach to nursing practice within the context of a just culture that focuses on improving human factors and systems within healthcare (Henrikson, Battles, Marks, & Lewin, 2005; McNab, McKay, Shorrock, Luty & Bowie, 2020;). The concept of systems thinking is difficult for nurses and other healthcare professionals when it is further contextualised with standards for professional practice that emphasise individual accountability for acquiring and maintaining an appropriate level of knowledge and skills to ensure that nurses provide safe and appropriate patient care.

When significant clinical incidents and adverse events occur in healthcare, system reviews such as RCA can be undertaken and applied to understand what happened, why it happened and how to prevent it from happening again. Queensland Health described this approach as a comprehensive or detailed analysis of a single incident that is undertaken when death or permanent harm has occurred, when the incident is complicated or complex, or when contextual pressures are high (Queensland Health, 2014a). System reviews and investigations of adverse events and incidents in public and private hospital settings in Australia consistently

identify factors related to knowledge, communication and failure to adhere to hospital policy as key causes of patient harm (Australian Institute of Health and Welfare, 2007; NHS, 2013; Queensland Health, 2012b; Western Australia Department of Health, 2010).

Patient safety and clinical governance systems, processes and outcomes are the context supporting this study. There have been significant downward influences from a governance system underpinned by accreditation and regulatory requirements that explicitly recognise the importance of policies and procedures in ensuring patient safety. Healthcare settings are complex, and nurses constantly deal with change and the practicalities of their everyday work. There are also constantly changing circumstances in healthcare, whereby uncertainty creates complexity and hence the relevance of focusing on in-situ practices to solve the problem of generalised rules and resources that do not take every day complexities into account is amplified (Iedema, Mesman, & Carroll, 2013). This introduction, in developing awareness of the problem of policy, informs the statement of the problem.

1.5 Statement of the Problem

During the process of undertaking system reviews relating to adverse clinical events, policy non-adherence or non-compliance is consistently identified as a contributing factor to the adverse event. This is an obvious and difficult problem relating to hospital policy and nursing practice that is not being openly discussed. It is challenging to address and is perceived to be discordant with the requirements for health practitioners to perform to appropriate standards. Perhaps it is seen by some as a banal subject that is not a substantial problem and simply a bureaucratic process, or it is not consciously recognised or known to be an issue until a problem emerges as a result of undertaking a system review process for an adverse event. Policies and procedures are low-level administrative controls that are the least effective at minimising risk because they do not control the hazard at the source but instead rely on human behaviour and supervision. However, policies and procedures often make the list of recommendations in a

system review. They may be necessary to ensure that substitution, isolation and engineering controls are implemented more effectively. However, it is difficult to define or find evidence of the effect of policies and procedures on preventing future harm in every day nursing practice.

It is important to acknowledge and work with the everyday complexity that is common in healthcare settings, including how nurses' practice in their everyday work and how they work with other nurses, from novices to experts (Benner, 1985). Nurses are employed from different backgrounds and have varying levels of knowledge, skills and experience that contribute to their nursing practice, care delivery experience and subsequent patient impact, outcomes and patient experience. Therefore, to understand the problem, a research approach is undertaken that sets out to identify and validate or challenge the anecdotal view that there is a problem with policy and nursing practice.

The problem posed in this thesis is that nurses do not read or know every policy and procedure that relates to their everyday practice. The requirements of what to know in order to provide safe and high-quality patient care can change within a shift or from shift to shift, depending on the needs and experiences of patients in their care. However, there is an organisational and professional expectation that all nurses know and will comply with all relevant policies and procedures related to their practice. When a system review is undertaken in relation to an adverse event, the issue of policy non-adherence or non-compliance repeatedly arises as a theme to be addressed in order to prevent patient harm in the future.

In discussions held with nurses before commencing the research, the researcher found that they already knew about these problems related to their everyday work, but they did not feel comfortable openly discussing them. This view challenges the existing rhetoric about clinical governance and quality and safety standards that are believed to be in place through various frameworks and policy structures within healthcare organisations. It is not known what nurses think about this, or indeed whether they think about it at all in their everyday work. Thus, this

thesis sets out to explore and respond to the problem posed, and to challenge the dominant rhetoric that having policies in place that all nurses have read and understood will always ensure safe and appropriate care. The voice of nurses will be empowered to share their lived experiences of what really occurs in their everyday work. The aims of the study assist in clarifying the focus of the study.

1.6 Aims of the Study

The problem relating to policy and nursing practice drives the exploration of the relationship between hospital policy and nursing practice, with the aim of gaining a greater understanding of the phenomenon from the perspective of nurses in their everyday work. Acknowledging and describing the multiple truths that exist in this practice–policy space is viewed by the researcher as an important way of gaining a greater understanding of nursing practice strengths and challenges through the lens of policy and clinical governance. The initial exploration of this topic attempts to understand the researcher's own observations of discontent and sense-making relating to how policy and nursing practice are perceived and enacted in nurses' everyday work. As the researcher's role and experience has grown over years of nursing in public and private healthcare settings, a personal awareness of the rhetoric around policy has evolved. The implementation of evidence-based practice compared with the reality of nurses' everyday work by those who investigate incidents and adverse events, and who establish and evaluate clinical governance frameworks, is being challenged with this rhetoric.

The overarching aim of this study is to understand the relationship between hospital policy and nursing practice from the perspective of nurses in their everyday work. To explore this, the study focuses on three specific aims, which are to:

a) identify what is known about the relationship between hospital policy and nursing practice through nurses' experiences and everyday work;

b) understand the global, national and local views of nursing practice, their meaning and relationship with hospital policy; and
c) describe the relationship and meaning between hospital policy and nursing practice in the everyday life of nurses in this study setting.

These aims emphasise that frontline nurses play a critical role in everyday nursing practice and are important in helping to develop an awareness and understanding of the nature of policy and nursing practice. Further, asking nurses to explore their experiences with hospital policy and nursing practice is important to better understand the phenomena. A comprehensive literature review and data collection from local organisational incident systems and triangulation are used to identify, understand and describe the relationship between hospital policy and nursing practice in the study setting.

1.7 Scope of the Study

This study was undertaken within three private hospitals that operate in Queensland, Australia, with registered nurses selected as the main participant group. Two of the hospitals are acute tertiary referral private hospitals—one in a metropolitan setting and the other in a regional setting. The third hospital is a sub-acute hospital in a metropolitan setting. Initially experiences of nurses were explored from one private hospital, followed by further exploration across the three private hospitals. To explore the relationship between hospital policy and nursing practice within a similar clinical setting across the three hospitals, a medical ward in each hospital was chosen as the study setting. The medical ward was selected to target potentially similar types of exposure to and experiences of clinical incidents and adverse events, as well as common language used in similar patient cohorts.

It is recognised that nurses work in a multidisciplinary workforce across each hospital; however, the study is limited to the experiences of registered nurses providing patient care at the point of care. The lens through which the study is undertaken is a clinical governance, safety and

quality approach in the application of hospital policy and nursing practice within the research approaches outlined in the study. The research targeted nurses working that are registered with the Australian Health Practitioner Registration Authority (AHPRA). The first standard of the Registered Nurse Standards of Practice, which was published by the Nursing and Midwifery Board of Australia (NMBA), is "thinks critically and analyses nursing practice" (AHPRA, 2016). This standard is explicit regarding the role of nursing in reflective practice and policy compliance. It requires registered nurses to use a variety of thinking strategies and the best available evidence when making decisions in order to provide safe, quality nursing practice within person-centred and evidence-based frameworks. Registered nurses must:

1. access, analyse and use the best available evidence, including research findings, for safe, quality practice;
2. develop practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice;
3. respect all cultures and experiences, including responding to the roles of the family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures;
4. comply with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions;
5. use ethical frameworks when making decisions;
6. maintain accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations; and
7. contribute to quality improvement and relevant research.

1.8 Significance of the Research

This research is significant to nursing practice within the context of the researcher's experience and the prevailing healthcare industry clinical governance, quality and safety culture.

The research will increase awareness of the relationship between hospital policy and nursing practice, and provide a path towards identifying, understanding and describing the relationship between policy and nursing practice in the everyday work of frontline nurses. This study will provide evidence regarding the relationship between hospital policy and nursing practice, and it will challenge assumptions and approaches embedded by regulators, accreditors and managers. There is a need to rethink the role of hospital policy in everyday nursing practice and the approaches required to maintain safe and high-quality care within the current complex healthcare settings. This study will make recommendations about how to approach the problem of hospital policy and nursing practice within a clinical governance context.

1.9 Conclusion

This chapter has laid the foundation for the study. It has provided the rationale for embarking on this research study and situated the research within the context of a problem whereby hospital policy and nursing practice differ from the expectations held by regulators, accreditors and managers, and nurses working at the frontline of clinical practice. The chapter also outlined related problems with hospital policy and nursing practice within the clinical governance, quality and safety domains. The researcher's context was then outlined, along with an introduction to the role of policy in the healthcare environment. A statement of the problem identified that during the process of undertaking system reviews relating to adverse events, policy non-adherence or non-compliance are consistently identified by regulators as contributing factors to these events. This occurs within a professional practice framework whereby hospital policy awareness and compliance are expected from the health practitioner registering body. This chapter also discussed the significance of the study, which will enhance the exploration of what is known about hospital policy and nursing practice within the study setting and its associated healthcare context. In the following chapter, the literature review will provide a further understanding of the relationship between hospital policy and nursing practice. Finally, this

chapter discussed the context that contributed to the researcher's motivation to undertake further study of the relationship between hospital policy and nursing practice.

Chapter Two: Literature Review

2.1 Introduction

The previous chapter presented the problem, aims, scope and significance of the study. This chapter situates the research within the existing literature, the frame of reference of hospital policy and its relationship to nursing practice. It emphasises the importance of developing a greater awareness of how policy is framed in the context of this research. Policy context (i.e., the global and national views of hospital policy) is examined through a clinical governance lens, and the complexity involved in understanding this topic and research approach is discussed to provide a better understanding of the existing knowledge that informs the research conducted in this thesis. The review of relevant literature and policy documents, which is conducted through a clinical governance lens, provides background to the research topic and a direction for this study.

The reviewed literature addressed health policy at the macro level (in this thesis, 'macro' refers to public health policy and global or national policy at a broad level) and was then distilled to focus on the meso level (in this thesis, 'meso' refers to organisation-wide policy, such as Queensland Health policy or a private hospital group policy) and the micro level (in this thesis, 'micro' refers to hospital policy at the local level) over the duration of the research study period to ensure that both seminal and contemporary literature sources were considered and analysed. That is, the review focused on regulatory, hospital and local department levels of hospital policy. This chapter analyses how current literature describes problems identified with hospital policy and nursing practice. It is here that the gap in knowledge is revealed, which justifies the direction of this research.

2.2 Literature Review Approach

Many studies have been conducted to examine specific issues relating to hospital policies and their relationship to the field of nursing practice. This review focuses on literature relating to the nature and context of hospital policies and how they typify the influence on nurses and their practice. The inclusion criteria for the databases searches considered the key aspects of the study, including hospital policies and procedures and their influence on nursing practice with respect to management and regulation; evidence-based practice; quality and patient safety; and culture and change in the context of the global and national health systems. These themes reflect the clinical governance lens through which the literature review was undertaken.

The exclusion criteria disregarded sources that did not address the concept of hospital policy and its influence on the practice of nursing at the meso or micro levels. Therefore, the researcher excluded sources that addressed the effect of hospital policy on the performance of healthcare professionals other than nurses, or that focused on other clinical or professional workplace settings and broader public health policy literature. To facilitate the literature review, a mega-search of several databases and journals was undertaken, including the *Australian Journal of Advanced Nursing*, *Journal Storage* (a digital library referred to as *JSTOR*) and the *Cumulative Index of Nursing and Allied Health Literature (CINAHL).* The inclusion criteria for the search were that the articles had to be full text, peer-reviewed, written in the English language and address the various topics associated with the study. Both empirical and grey literature were considered in the literature review. Grey literature refers to materials and literature produced by healthcare organisations and government bodies outside of published peer-reviewed journals and literature, as these were considered by the researcher to inform the clinical governance context of the study. The grey literature cited in this thesis was part of a secondary review that used the terms listed below.

The key terms used in the searches included:

- hospital policy and nursing practice;
- hospital policies and procedures in nursing practice;
- hospital policy in Australia and its influence on nursing practice;
- evidence-based approaches;
- policy adoption;
- policy and quality and patient safety;
- policy non-compliance; and
- policy non-adherence.

Time and language parameters were set to include sources published in English between 2000 and 2020, with some targeted reviews of seminal texts published before 2000 to reflect the references that remain relevant today. The database searches from 2000 to 2020 generated 321 results, of which 101 were relevant and therefore included in the literature review. The review focuses on relevance to the research area and identifies a number of themes, including the manner in which hospital policies affect nurses' perceptions and performance. The majority of journal articles provided individual reviews and assessments of the efficacy of, or relationship between, policy and a particular area of practice or practice location.

2.3 Themes in the Literature

The search for and analysis of empirical and grey literature highlighted key themes that will be discussed in further detail, including:

- policy defined by regulators and accreditors;
- global view;
- Australian view;
- policy context in hospital settings;

- quality, patient safety and policy;
- policy implementation;
- culture, change and policy;
- evidence–practice gap; and
- policy rhetoric and management.

2.4 Policy as Defined by Regulators and Accreditors

Understanding how policy is defined is an important consideration for the context of this research study. Resource documents from professional healthcare, regulatory and accreditation bodies were used to inform the breadth of understanding of the research topic. The term 'policy' is used as an overarching descriptor of the many types of documents and processes that cascade from this concept, such as policies, procedures, protocols, processes, guidelines, safe operating procedures and work instructions. These descriptors are used to varying degrees in hospitals and local clinical work areas in Australia and overseas. Regulators and accreditors have used many definitions of the term 'policy', with all emphasising the top–down approach that healthcare providers are required to integrate into their services in this area. The registered nurse Standards for Practice (2016) explicitly state that registered nurses should comply with:

> "legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions". (p. 3)

However, the nurse Standards for Practice do not explicitly define the legislation, regulations, policies, guidelines and standards; rather, these practice standards are expected to be integrated with the Australian Commission on Safety and Quality in Health Care (ACSQHC) policy requirements and hospital accreditation requirements. For registered nurses working in private hospitals in Queensland, the standards of practice also require them to comply with the *Private Health Facilities Act (1995)* and *Private Health Facilities Regulation (2016)*. These acts and regulations are administered by the Private Health Licensing Unit in Queensland Health,

operating under the direction of the Chief Health Officer. The minimum requirements for providing health services are laid out in the Private Health Licensing Unit's (Queensland Health, 2018, p. 14) Clinical Services Capability Framework (CSCF) for Public and Licensed Private Health Facilities version 3.2 Fundamentals of the Framework. Key assumptions underpinning the CSCF include:

> "health facilities comply with relevant legislative requirements, standards, guidelines and benchmarks including organisational policies such as informed consent, fatigue management, infection control and quality processes" (Queensland Health, 2018).

Thus, registered nurses working in private hospitals in Queensland must comply with their registration body and state legislation and follow their hospital's policy and standards frameworks, as well as its requirements for accreditation. As providers of health services, under their private licensing requirements, hospitals must have systems and processes in place to ensure that their employed and visiting health practitioners are aware of and practice within these organisational policies, procedures and frameworks. This ensures that the organisation complies with its legislated requirements, but it creates conflict between what is required from a regulatory perspective and what is actually practiced in the management and provision of healthcare to patients in nurses' every day work.

Accreditation in private hospitals in Queensland is undertaken to comply with the NSQHSS as defined by the ACSQHC (2017a) and an approved accreditation agency, pursuant to the *Private Health Facilities Regulation (2016)*. Until 2019, approved accreditation agencies under the *Queensland Private Health Facilities Act* and regulations included organisations such as the Australian Council of Healthcare Standards (ACHS) and the International Organization for Standardization (ISO). In 2019, changes to the provisions of the *Health Services Act (Queensland)* removed the requirement for ACHS or ISO accreditation and upheld the requirement for accreditation against NSQHSS second edition and the National Model Clinical

Governance Framework. During the period of the research, the hospitals in this study had to ensure that their policy frameworks and processes aligned with the requirements of both the NSQHSS and the chosen accreditation agency, such as the ACHS Evaluation and Quality Improvement Program (EQuIP) (Queensland Government, 2016).

In its summary of matters relating to governance and leadership, the ACSQHC (2015, p. 9, 2019) stated that the board, through the senior hospital leadership, was responsible for:

> "ensuring the organisation maintains a comprehensive set of organisational policies and associated procedures and protocols and reviews them regularly".

Further, the board needs to:

> "provide direction for the operation of the organisation, address clinical quality and safety and be consistent with the regulatory obligations". (ACSQHC, 2015, p. 9)

In practice, hospitals undergo accreditation through an ACSQHC-approved accreditation process to demonstrate publicly reported evidence of their attestation to meet these requirements. The ACSQHC (2017a, p. 333) provided definitions of terminology used in the NSQHSS second edition, including policy as,

> "a set of principles that reflect the organisation's mission and direction and where all procedures and protocols were linked to a policy statement".

These definitions have remained unchanged since at least 2011 (ACSQHC, 2017a). A procedure is defined as a:

> "set of instructions that made policies and protocols operational and were specific to an organisation". (ACSQHC, 2017a, p. 333)

A protocol is identified as another term related to policy and is described as:

> "an established set of rules used for the completion of tasks or a set of tasks". (ACSQHC, 2017a, p. 333)

The NSQHSS second edition provided explicit requirements for the development and management of policies and procedures for each standard (ACSQHC, 2017a, p. 30). The present study was conducted following the implementation of the initial NSQHSS; however, the policy requirements are generally consistent in the second edition, if not more explicit. The NSQHSS second edition clinical governance standard 1.7 refers to hospitals using a risk-based approach to:

> "set out, review and maintain the currency and effectiveness of policies, procedures and protocols; monitor and take action to improve adherence to policies, procedures and protocols; and to review compliance with legislation, regulation and jurisdictional requirements". (ACSQHC, 2017a, p. 30)

The NSQHSS second edition clinical governance standard further outlines the policy processes, governance systems and structures required to support policy development, implementation, monitoring and evaluation (ACSQHC, 2017a). It emphasises the roles and responsibilities of governing bodies and senior leaders in ensuring that the standard in place and actively managed, and strongly emphasises a downward approach to policy processes and management. In part, this reflects the regulatory environment and legislative compliance responsibilities of governing bodies and senior leaders, and places an explicit responsibility on the high level of governance and delegation accountabilities and responsibilities. Policy resides within a pivotal space in the clinical and corporate governance domains of healthcare.

The NSQHSS second edition provided a roadmap for organisations to take part in making progress towards providing safe and effective healthcare. Policies, procedures and protocols are a fundamental part of an effective clinical governance system within healthcare. The integration of all policies, procedures and protocols into a single coherently designed system, as outlined in

the NSQHSS second edition, enables healthcare organisations to function with utility. The ACSQHC (2017a) outlined the patient safety and quality systems criterion of the NSQHSS second edition, whereby policies, procedures and protocols included the following topics:

> "developing policies, procedures and protocols; monitoring the reporting clinical performance; managing clinical risk; managing and reporting adverse events, including reporting on sentinel events; managing complaints and compliments; managing open disclosure; and engaging clinicians in planned, systematic audits of clinical services following agreed protocols and schedules". (ACSQHC, 2017a, p. 30)

The NSQHSS second edition explanatory notes provided an opportunity for organisations to use the policy process (i.e., during the creation or review of policies) to convey their approach to a learning culture, to enable active participation of all staff in safety and quality, and to provide support for staff and patients involved in incidents and adverse events. This can be interpreted as an invitation for bottom–up involvement in policy processes. However, it is unclear how this occurs in different organisations; it may be depending on the lens or perspective through which it is viewed by hospital management. The NSQHSS second edition encourages committees to be actively involved in policy processes related to ensuring quality and safety in the system, which can enable middle management to have some influence on policy processes (ACSQHC, 2017a). However, in every day nursing practice, this is likely to have limited reach to frontline staff unless they are on those committees. The NSQHSS second edition is explicit in its reference to ensuring easy access to policies and requiring staff to comply with organisational policies, procedures and protocols included in their position description (ACSQHC, 2017a). All healthcare organisations were required to implement the NSQHSS second edition from January 2019 (ACSQHC, 2017a). The policy and procedure criterion in the NSQHSS second edition further required organisations to maintain information about non-compliance with hospital policies, procedures and protocols and that should incorporate, where appropriate, into both risk

registers and quality improvement plans. A strong downward and compliance-oriented approach to policies in healthcare organisations is reflected.

The accrediting bodies approved by the ACSQHC to conduct audits on health service providers also presented definitions of 'policy' and 'procedures' to provide further context. The Australian Council on Healthcare Standards Evaluation and Quality Improvement Program (ACHS EQuIP) provided definitions of the terminology used in their standards to supplement the NSQHSS second edition, defining policy as:

> "written statements that acted as guidelines and reflected the position and values of the organisation on a given subject"

and where:

> "all procedures and protocols were linked to a policy statement". (ACHS, 2015, p. 50)

The purpose of a policy is to provide a:

> "clear, documented statement of the expectations of tasks and concepts that was consistent with organisational objectives". (ACHS, 2015, p. 50)

Although a policy is like a decision, the ACHS clarified that a policy is not a one-off independent decision; rather, it is a:

> "set of coherent decisions with a common long-term purpose". (ACHS, 2015, p. 50)

When a policy is developed by jurisdictional bodies, an organisation may use guidelines, procedures or another type of document to address the implementation of the policy (ACHS, 2015). A procedure is defined as a:

> "set of documented instructions conveying the approved or recommended steps for a particular act or sequence of acts, where there are specific methods employed to

> implement and carry out policies in the day to day activities of the organisation". (ACHS, 2015, p. 50)

Guidelines are defined as:

> "principles guiding or directing action, and that a guideline could be any document that aimed to streamline particular processes according to a set routine". (ACHS, 2015, p. 50)

According to the ACHS (2015), while following a guideline is not considered mandatory, 'protocol' is a better term for a mandatory procedure.

The ACSQHC (2017, p. 333) described policy as a:

> "set of principles that reflected the organisation's mission and direction".

The ACHS (2015, p. 50) described policy as:

> "a written statement that acted as guidelines and reflected the position and values of the organisation".

On the surface, these definitions appear to be consistent across the accrediting bodies; however, the ACHS (2015, p. 50) also described guidelines as:

> "principles guiding action".

Again, on the surface, these definitions appear to be consistent with that of the ACSQHC (2017a). However, the ACHS (2015) also stated that it is not mandatory to follow a guideline, and that a protocol is more likely to be mandatory. If a policy is more like a set of coherent decisions with a common long-term purpose than a one-off decision, it is unlikely to be applied to specific patient situations and always be best practice. Further, if a policy is a guide to practice, there should be an appropriate process for safely applying the guide to the specific patient situation. Thus, the research study approach for this thesis is informed by the gap in

policy and practice between frontline nurses in their everyday practice and managers and accreditors.

2.5 Policy Context in Hospital Settings

Healthcare policy has been defined as a collection of governing laws and regulations that facilitate the attainment of quality and safe care delivery and encourage cost-effectiveness (O'Donnell & Vogenberg, 2012). Further, procedures have been defined as roadmaps established by healthcare facilities to facilitate the implementation of a particular policy or way of delivering services (O'Donnell & Vogenberg, 2012). Procedures encompass the different types of tasks performed by nurses and other hospital staff to implement a policy or provide a desired service. However, most hospitals prioritise policy formation and leave out the crucial aspect of implementation (Kelly, Garvey, & Palcic, 2016). Consequently, nurses may fail to observe the required procedures that foster the quality of care delivery, thereby undermining the reachability of basic goals of care. This emphasises the problem with policy formation over implementation, which affects frontline nursing practice because the policy may be in place but it is not entirely synthesised into nurses' everyday practice.

There are types or categories of policies and procedures used in hospital settings that affect nursing practice. Both clinical and non-clinical policies and procedures are relevant and necessary for nurses. The major types of policies that affect the nurses' practice in the hospital organisation are administrative, human resource management, care provision, medicine and information management policies according to Braithwaite (2006). Thus, hospital organisations need to ensure that nurses provide their services in line with the provisions of the various types of policies.

It is crucial for hospital management to establish effective administrative policies that enhance the role of nurses in streamlining the operations of the hospital (Cogin, Ng and Lee, 2016). Administrative policies form the backbone of operations in healthcare facilities, so it is

important to create a workplace environment that fosters the adoption of such policies and procedures (Dawson, Stasa, Roche, Homer, & Duffield, 2014). The common provisions of hospital administrative policies and procedures in Australia relate to dress codes, visitations, beds and the acquisition of equipment (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). Overall, administrative policies and procedures provide guidance to nurses and other professionals in the hospital environment to ensure that their performance contributes to the efficiency of the organisation.

The literature emphasises that a broad all-of-organisation approach is needed for policies and procedures that relate to nursing practice. This reflects a broader understanding of policy compared with a focus on an evidence-based approach. Nonetheless, Pascoe, Foley, Hutchinson and Watts (2005) insisted that without the integration of practical human resource management policies and procedures, an organisation's administrative policies become dysfunctional in the Australian health system. Human resource management policies and procedures focus on providing the necessary care to workers in addition to ensuring that they observe the rules and regulations established by the hospital (Dawson et al., 2014). This can be seen in workplace health and safety policies and procedures, which are entwined with the fabric and physicality of nursing practice delivered to patients. Therefore, by ensuring that nurses and other health practitioners comply with the various policies and procedures in the hospital environment, human resource policies foster the implementation of administrative policies. Human resource departments in hospitals need to establish policies and procedures that strike a balance between providing care to employees and directing them to attain the goals set by the organisation (Pascoe et al., 2005). In this respect, providing adequate care to nurses is integral because the approach influences their commitment and motivation to provide quality care services, which is a primary goal in any given healthcare system.

Policy and procedure manuals are an important source of knowledge and help nurses to apply evidence-based approaches in the delivery of care services in Australia. An article about a

nursing whistleblower stated that it is important for Australian hospitals to increase the accessibility of policy and procedure manuals to nurses, who play an important role in enabling the provision of high-quality care to clients (Jones, 2005; Kneafsey, Clifford, & Greenfield, 2015). Accessibility of hospital policy and procedure manuals is crucial because they provide important rules and regulations regarding topics such as admission and discharge, patient and family education, abuse and neglect, patient rights and responsibilities, and other aspects of care delivery (Kneafsey et al., 2015). As such, hospital management needs to employ measures, for example, by fostering the accessibility of relevant manuals and to ensure that nurses implement care provision policies. This literature review also highlights a gap in the research relating to electronic policy database development and implementation of paper-based policy manuals in Australia. In the context of the current digital environment, research needs to be conducted to better understand the effect of digital versus paper-based policy implementation and access.

In understanding the jurisdictional and accreditation requirements around policy, hospitals and their nursing staff must comply with a range of policies and procedures that guide their delivery of care and services to patients. Various policies and procedures established in the hospital setting pursue specific aims regarding accreditation and regulatory requirements; thus, it is essential for all healthcare stakeholders to comply with the different types of policies and procedures. Formalised and written hospital policies and procedures have vital purposes, such as promoting adherence to acknowledged professional practices, as well as various accreditation requirements, statutes and regulations (Cusack et al., 2015). The multiple types of policies and procedures in the hospital environment facilitate the reduction of practice variation through the standardisation of practices across numerous units within a single health system (Cusack et al., 2015).

The standardisation of practices has influenced nurses' performance by underlining the need for inputs that result in high-quality service provision, thereby contributing to improving the wellness of the entire health system (Maier, 2015). Policies and procedures in the hospital

environment are an essential resource for professionals, especially newly registered nurses, who are unlikely to have developed a wide range of skills, experience and knowledge in all relevant areas of nursing practice (Heale & Rieck Buckley, 2015). Similarly, Brady, Malone and Fleming (2009) underlined that policies and procedures provide a vital knowledge resource for both new and experienced nurses in terms of reducing over-reliance on memory, which the authors considered a significant trigger of errors in nursing practice. Thus, policy and procedure manuals are essential because they facilitate the prevention of errors and support evidence-based practice to realise quality services and patient safety, which are goals of any given health system (Jones, 2005). It is critical for hospital-based organisations to integrate the various types of policies and procedures in a way that encourages nurses to perform in line with the required rules and regulations, and thus contribute to the attainment of shared goals and objectives in the health system.

In the healthcare setting, the purpose of policies and procedures is to standardise the daily operation of activities (Heale & Rieck Buckley, 2015). Hospital managers need to uphold the importance of policies and procedures because they help provide clarity when handling issues and activities that are essential to health and safety, regulatory requirements, and legal liabilities (Westbrook et al., 2015). In this respect, hospital policies and procedures play an integral role in ensuring that organisations operate effectively and efficiently to help nurses provide appropriate services to patients. Therefore, it is important to prioritise the establishment of effective and efficient policies in the healthcare sector as healthcare providers pursue the provision of high-quality services to patients in line with the relevant legal framework. It has been argued that a considerable number of healthcare organisations have not put in place best management practices to facilitate the proper implementation of policies and procedures (Ploeg, Davies, Edwards, Gifford, & Miller, 2007). This affects the performance of healthcare professionals, including nurses, to the extent of undermining the realisation of safe and high-quality care.

A study conducted by Maier and Aiken (2016) asserted that hospital management must prioritise the use of policies and procedures among nurses and other healthcare professionals in the hospital environment. This approach is considered crucial because it bolsters the efficiency and productivity of nurses and ensures that hospitals do not breach any rules and regulations in the sector. Similarly, Westbrook et al. (2015) noted that hospital policy is essential because it guides healthcare experts to attain desired outcomes. Thus, for hospitals to achieve primary goals such as the provision of high-quality services besides integrating patient safety, it is important for the management team to communicate the hospital's policies and regulations effectively and efficiently. Communication of the hospital's action plan on policies and procedures is critical because it guides the decision-making processes of healthcare professionals, including nurses (Bahr et al., 2017). In addition to fostering the decision-making processes of nurses, the proper communication of hospital policy enhances nurses' understanding of their roles and responsibilities (Bahr et al., 2017). Jurns (2019) described communication with patients using ISBAR (Identify, Situation, Background, Assessment, Recommendations): I (identify who you are and whom you are speaking about), S (situation you are describing about your patient), B (obtain background relevant to the patient and situation), A (conduct an assessment of what is occurring) and R (recommend a course of action). ISBAR is a practical way for nurses to communicate about policy (Jurns, 2019). Even nurses who are inexperienced in policy issues can foster greater participation and positive perceptions in narratives about policy by using this tool to structure their communication (Jurns, 2019).

Mosadeghrad (2014) found that hospital policies and regulations foster the establishment of standards that act as a benchmark in the assessment of quality and improvement in healthcare systems. In this respect, policies and regulations help set the standards that influence the actions of nurses to ensure that they facilitate the provision of quality services, as well as the overall improvement of the healthcare sector (Mosadeghrad, 2014). Further, Hutchison (2016) argued that the policies and procedures established by hospital administrators should aim to positively

influence nurses' patterns of practice, expectations and consistency. However, de Vries and Timmins (2017) underlined that while most hospital policies and regulations focus on bolstering the realisation of patient outcomes, they have little concern for the effect on nurses, thereby inhibiting the overall improvement of the healthcare system. De Vries and Timmins (2017) argued that improvement in healthcare is a focus that emphasises the proactive role of hospital management in contributing to effective policy processes and patient outcomes, as well as efficiencies.

This is further supported by a study by Braithwaite (2004), who demonstrated that the work of clinician managers is more concerned with inputs such as managing finances, people and things rather than systems and outcomes, which are the important outputs measured in safe and high-quality healthcare systems. According to Braithwaite (2004), managers undertake sense-making, which involves considerable intellectual energy, with little evidence that they plan strategies or develop policy in a deliberate or organised manner. This raises a question of how ensuring safe systems for patients following evidence-based practice through standards and policy can become a priority, or even a reality, in such a system and culture (Braithwaite, 2004). Given the extensive regulatory and accreditation frameworks driving policy formation and structure, this challenges what really occurs in everyday nursing practice in regard to policy implementation and application. An aim of this study is to explore and better understand how policy processes fit within the clinical governance program and integration with standards and compliance that are relevant or not relevant to frontline nursing practice. The literature review both supports and challenges the reality of the implementation of policies in healthcare settings, and this study provides an opportunity to explore and understand everyday nursing practice within the study setting. It is important to understand global and national views of hospital policy and nursing practice to further consider the context for the study.

2.6 Global Views on Hospital Policy and Nursing Practice

Global factors in the healthcare system inform approaches to the analysis of hospital policy implementation and evaluation through the standardisation of quality and safety measurement systems and a universal move to define quality outcomes (Schroth & Khawaja, 2007). Globalisation and ideologies related to healthcare and international organisations have an ongoing effect on policy development, implementation and evaluation. Patterns of consumerism in healthcare in other developed countries drive trends in healthcare, as information is made available to healthcare professionals and consumers through media, the internet and interest groups (Ioannou, Mechili, Kokokathi, & Diomidous, 2013). This complexity and rapid change in information further challenges the notions surrounding policy and how a nurse could know and keep up to date with all changes in literature and associated policy.

Safety and quality trends have moved in a global direction as a result of the increasing influence of the WHO on clinical governance programs and national and local policy drivers. The WHO (2018) described health as complete physical, mental and social wellbeing, and not merely the absence of disease. This definition draws attention to the broad nature of health and what influences it. While health programs often have high political priority, the healthcare systems that are used to implement them are varied and under pressure, especially in poorer countries (WHO, 2018). A major concern in less developed nations is the appropriateness of healthcare delivery (WHO, 2018). Evidence-based standards and policy standardisation, as well as tools and education resources, are targeted at both developing and developed countries (WHO, 2018).

The development of a national injury prevention policy in Australia began in 1981, when the WHO published the Global Strategy for Health for All by the Year 2000 (WHO, 1981). Members then developed national policies, strategies and action plans to improve health, and their effectiveness was monitored. Australia established the Better Health Commission in 1985

in response to the WHO's initiative (Salmond, 1986). Within this report, a review of the National Better Health Program showed that some progress had been made towards the Global Strategy, but the goals and targets had not been widely adopted. Mitchell and McClure (2006) highlighted the need for better and fuller engagement of the health system in the identification and monitoring of health targets, the development of accountability measures and the development of strategies to address social and environmental determinants of health. These programs have driven policy and procedure development at the national, state and local levels in key areas relating to safety and quality. A series of reports and committees over subsequent years established goals and targets around priority health areas, culminating in the development of the National Strategic Framework for Chronic Conditions, which focused on prevention for a healthier Australia (Australian Health Minister's Advisory Council, 2017; AIHW, 1997). The WHO has had a strong influence on driving evidence-based policy changes to clinical practice through programs such as the Save Lives: Clean Your Hands Global Patient Safety Challenge and the WHO's Guidelines for Safe Surgery 2009: Safe Surgery Saves Lives (WHO, 2009a, 2009b). These global initiatives have been integrated into local hospital policies, albeit with local culture adaptation.

The global view of hospital policy has rested on the idea of enhancing the performance of an organisation and thus improving wellbeing (Epstein, Fiscella, Lesser, & Stange, 2010). As such, hospital policies around the world should focus on improving stakeholders' wellbeing by upholding the essence of quality, safety and workplace culture (Braithwaite et al., 2017).

2.7 Australian Views on Hospital Policy and Nursing Practice

The Australian health system is considered one of the most effective and efficient in the world (O'Brien, Edge, & Clark, 2016). In this respect, healthcare policymakers globally may be justified in emulating Australian health policy processes as much as Australian policymakers may consider adopting the policy frameworks of other countries (O'Brien, Edge, & Clark, 2016).

The Australian view of health policy is rooted in the elements of quality, safety and accessibility to improve the wellness of the general population in line with global health policy (Griffiths et al., 2016). Global and national views on hospital policy have similarities amid the Australian system, denoting greater policy performance in the safety and quality domain compared with other countries.

The Australian healthcare system has faced an array of challenges that require hospitals in the public and private domains to adopt policies that lead to greater efficiency and effectiveness. In a recent review of the policy perspective of the Australian healthcare system, Dixit and Sambasivan (2018) argued that policymakers in Australian healthcare need to address the significant problems facing the sector, which include inefficiencies in resource allocation, performance and patient outcome improvements. Therefore, they proposed the adoption of policy implementation and bureaucratic models to improve the processes associated with the appropriate allocation of resources, and to improve the performance of professionals and patient outcomes. This approach was projected to result in not only the successful implementation of hospital policies in public and private healthcare organisations in Australia, but also the optimal standardisation of services. The focus on quality and patient safety in policy is a direct result of the implementation of the NSQHSS in Australian hospitals.

The Australian Hospitals and Healthcare Association (AHHA) (2018) noted that Australian healthcare policy is evidence-informed and therefore stands out as one of the most effective and efficient in the world. The evidence-informed policies advocated by the AHAA (2018) aim to result in healthy people and healthy systems. Thus, healthcare policy in Australia is directed towards achieving truly integrated and connected services within a complex system (Willis, Reynolds, & Keleher, 2016). Australian hospitals mainly establish policies that address important aspects of the system, including the provision of care, management of systems, information management, human resource management and funding (AHAA, 2018).

In a study of the increasing use of evidence in health policy, Campbell et al. (2009) revealed that policymakers in the Australian healthcare system have difficulty basing policy development on research because of the inaccessibility of relevant research synthesis. Hennink and Stephenson (2005) argued that collaboration between policymakers, researchers and practitioners is necessary to fill the existing knowledge gap in the area of health policy development and implementation in both developed and developing countries. In addition, Ellen, Lavis, Ouimet, Grimshaw and Bédard (2011) insisted that policymakers should consider the establishment of sound research knowledge infrastructure to streamline the development and implementation of hospital policy founded on knowledge.

Historical factors in the healthcare system have informed approaches to the analysis of hospital policy implementation and evaluation. The Australian healthcare system has developed over time to improve safety and quality approaches to clinical governance. The roles of government and peak industry bodies, as well as health reform and the development of healthcare standards, have been integrated with management and governance functions with a consistent focus on evidence-based policy driving system changes to help achieve this improvement (ACSQHC, 2017b). Hence, the National Model Clinical Governance Framework was launched in all Australian hospitals in 2018 (ACSQHC, 2017b).

Reliable information is critical for rational policymaking, and debates on health and hospital policy that are conducted with partial information result in the lack of strong outcome indicators, which hampers analysis of the overall system or effects of specific policy interventions (Poullier, 1990). Schumann (2016, p. 5) defined indicators as:

> "quantitative or categorical measures that provided information on conditions and developments that are relevant for the policy making process".

The authors (Poullier, 1190 & Schumann, 2016) cautioned that indicators have different uses, and although it is not possible to predict the effects of a policy, baseline information relating to

the policy can be obtained. According to Poullier (1990), while reliable information cannot guarantee a good policy, it is an essential ingredient, and a broad understanding is required to frame the global context of many areas of health and hospital policy. This is supported by Schumann (2016), who emphasised the complexity of modern policies and strong interdependencies and noted that it is difficult to predict their consequences with certainty. The policymaking environment is claimed to be increasing in complexity due to globalisation, increased use of technology, increased reliance on market mechanisms as policy tools, and an increased number of stakeholders and third parties (Gleeson et al., 2009). These factors make it difficult to predict the effect of policy changes in the long term, and hence latent conditions that may contribute to adverse events.

Federal and state government reports that were published between 2007 and 2016 in most states regarding sentinel events in hospitals identified that although the formats and reporting were different, common themes relating to policies, procedures and guidelines were reported as significant issues (see Table 2.1).

Table 2.1 Summary of reporting on policies and procedures related to sentinel events

Report	Reporting Body/ Reference	Summary—reference to policies and procedures, and sentinel events
	AIHW (2007). AIHW (2018).	In 2007-7008, the AIHW reported 130 sentinel events, with 42% of contributing factors referring to a breakdown in rules/policies/procedures (i.e., not understood, not followed or not available). Between the years 2007-2008 and 2015-2016, the rate of adverse events reported in hospitals increased from 4.8 to 5.4 adverse events per 100 separations. Sentinel events refer to a subset of adverse events resulting in death or serious harm for a patient.
Queensland Sentinel Event Learning to Action report 2007/2008	Queensland Government, Department of Health (2009).	Queensland Health reported that in evaluation of sentinel events, that 36% were identified as having policies and procedures as a contributing factor.
Fifth Queensland Health Report on Clinical Incidents and Sentinel Events in the Queensland Public Health	Queensland Government, Department of Health (2012a).	Queensland Health's most recent report on sentinel events was the Fifth Queensland Health report on clinical incidents and sentinel events in the Queensland public health system, 2009–10 and 2010–11. It did not report on contributing factors relating to the sentinel events reported during this period.

Report	Reporting Body/ Reference	Summary—reference to policies and procedures, and sentinel events
System, 2009–10 and 2010–11		
NSW Sentinel Event Annual Report 2008/2009	NSW Government, Department of Health (2010).	NSW Health did not report data in percentages, however described policies and guidelines as the most common contributing factor for sentinel events.
New South Wales Health Electronic Dashboard	NSW Government, Department of Health (2017). NSW Government, Department of Health (2018).	NSW Health moved to an electronic dashboard and reporting process 2013–2017. The top three system factors identified by the Clinical Management RCA Review Committee for SAC1 incidents reported between 2013 and 2017 related to *Care Planning*, *Communication*, and *Policy and Guidelines*. During the January to June 2017 reporting period, the system factor *Policy and Guidelines* replaced *Assessment* as the third most identified system factor. The system factor *Policy and Guidelines* is applied to incidents where it is identified that there is no policy or guideline, where existing policies and guidelines have not been implemented by a staff member or organisation, when a policy or guideline is not in line with NSW Health policy or evidence-based practice, when it is not available or when it is unclear or unworkable.
Victorian Sentinel Event Annual Report 2009/2010	Department of Health, Victoria (2011).	Procedures and guidelines were a contributing factor in 60% of sentinel events.
Victoria Government Sentinel Event Triennial Report 2013 to 2016	Department of Health, Victoria (2017, p.32).	295 contributing factors were identified for sentinel events reported to the program. The most frequently identified contributing factors were procedures/guidelines, including availability, currency of and compliance with the clinical guidelines that govern behavioural and physical assessments, patient observation, patient/site identification and coordination of care (27%), communication (16%) and human resources (15%). Policies and guidelines as a contributing factor were evident across every category of sentinel event. However, the report highlighted that, "the collection of information during the review of sentinel events is often insufficient to inform future practice. This hampers the ability of Safer Care Victoria to identify trends and support health services in patient safety improvement".
Western Australian Sentinel Event Annual Report 2009/2010	Department of Health, Western Australia (2011).	Procedures and guidelines were a contributing factor in 80% of sentinel events reported.
Western Australian Sentinel Event Report 2005/2016	Department of Health, Western Australia (2016).	The Western Australia Government reported on 403 sentinel events reported in 2015 and 2016. The most frequently identified contributory factors related to communication issues (n=267; 53%), followed by policies/procedures/guidelines and patient factor issues (n=264; 52.4%). This was compared with sentinel event reporting in the previous two years, with policies/procedures/guidelines reported as a contributing factor in 66.7% of sentinel events in 2014/2015 and 70.7% of sentinel events in 2015/2016.

While the sentinel events reported across each state were different, the narrative continues to reflect a consistent message that policy, procedures and guidelines are a significant contributing factor to all types of sentinel events in public and private hospital settings in

Australia. Further, the various state reports that identify the contributing factor effect of policy, procedures and guidelines on sentinel events do not recommend any significant responses or strategies to address this identified area that contributes to clinical risk. The issue remains, and there is an evident gap in understanding the issue and response, thereby emphasising the continued significance and relevance of this area of research.

Analysis of the reports (see Table 2.1) confirmed that there is a problem with policy insofar as hospital policy featured consistently as one of the most common contributing factors to clinical incidents and adverse events. There is limited evidence of understanding of the relationship between policy and nursing practice in published material or derived from system review reporting. Safer Care Victoria argued that RCA or sentinel event reporting is insufficient to inform future practice (Department of Health, Victoria, 2017). This criticism of RCA or sentinel event reporting challenges the approach of reviewing reports to understand the phenomenon. Thus, research is required of how to explore and gain a greater understanding of the local processes and practices, as well as the lived experiences of nurses at the frontline, in order to more directly understand how nurses make sense of the relationship between hospital policy and local nursing practice.

Following a range of inquiries, Australia developed state and national policy drivers and incentives to monitor and manage clinical risk. The management of health services in Australia is challenging, and a broad understanding of the context of the health system is necessary to critically analyse the key factors affecting how health service managers operate (Duckett, 1994). Complexity has been identified in relation to the growth of new technologies, medications and medical devices, and there has been continuous growth in knowledge through research (Balding, 2005). In complex systems such as hospitals, unpredictability has always been evident and organisational functions have been interdependent, self-adjusting and constantly interacting in a paradigm of dynamic complexity (Plsek & Greenhalgh, 2001). At each level, health service managers faced issues related to management processes and theory; complex and dynamic non-

linear systems; safety, quality and change management processes to improve transparency and accountability; and efficiency and effectiveness (Balding, 2005; Donabedian, 1966; Duckett, 1994; Shortell & Kaluzny, 1994; Sorenson et al., 2005; Wilson, 2004). Acute care continues to tolerate a high level of risk in the way tasks are performed and measured. This culture and the lack of reliable data continue to mask individual and system failures (Balding, 2008).

Duckett (2016, p. 18) further challenged the concept of preventability in adverse events to improve safety of care, including differing definitions, challenges with inter-rater reliability in the use of definitions, changes in preventability over time and an inability to separate the patient's outcome in relation to complex causation. In addition, facility-specific diagnostic technologies make preventability location-specific, and a binary conceptualisation of preventability may prevent the possibility of reducing rates of complication, even if they are not preventable in all patients. The author acknowledged that the rate of hospital-acquired complications (HACs) is significant, stating that "about one in every eight patients had some complication during their stay". While contemporary approaches to patient safety aim to understand complex system issues, Duckett (2016) argued that, in an effort to learn and continuously improve practice, the focus should be on learning rather than compliance with policy or other contributing factors.

The ACSQHC (2018a) included ten national safety and quality health service standards in the first edition and revised the accreditation processes for healthcare organisations and the reporting of performance against the standards. This was superseded by the NSQHSS second edition, which entered into effect in January 2019 (ACSQHC, 2018a). The NSQHSS aims to improve safety, standardise processes (based on evidence), implement quality improvement practices and provide a quality basis for healthcare funding (ACSQHC, 2010a). The NSQHSS second edition recognised the important role of flexible standardisation of processes in improving patient safety; however, processes need to be designed and integrated to fit the context of the organisation and the individual patient (ACSQHC, 2012). The standardisation and

integration of processes poses a challenge to ensuring that evidence-based practice, regulatory requirements and external policy are reflected in tools, processes and protocols.

Policies, procedures and the implementation of evidence into practice have been and still are key aspects of the standards; however, the governance standard in particular has focused on improving leadership engagement (ACSQHC, 2018a). The ACSQHC (2018b) described safety and quality monitoring systems to measure a wide range of elements relating to patient safety to obtain an integrated view of patient safety across these elements. It continued to work on bringing together these elements; however, despite the significant explicit requirements around policies and procedures, these were not well measured or implemented. Measures were based around core hospital-based outcome indicators (CHBOI), HACs and patient experience measures; however, while valuable, these measures did not and still do not provide any evidence in relation to policy processes, appropriateness, effectiveness and contribution to outcomes. The ACSQHC (2018a) supported the impending implementation of the NSQHSS second edition, effective from 1 January 2019, which further emphasised the importance of policy and procedures in relation to the eight national standards in the new format.

There are increasing demands for organisational responsiveness and accountability. Organisations need to position themselves to effectively manage change in order to meet compliance standards. Responsive regulation has emerged in Australia as a moderate strategy to address the complexity, with stronger emphasis placed on meta-regulation via central policy frameworks and standards. Responsive regulation is an emerging strategy aimed at improving safety and quality in healthcare (Healy & Braithwaite, 2006). The accreditation and regulatory requirements for policy are monitored by a number of agencies and bodies. The link between patient outcomes and evidence, policy and practice, was emphasised and scrutinised under the guise of clinical governance frameworks and policy programs. This link works most effectively when the top–down approach meets the bottom–up approach, and when staff are involved at each level of the organisation. This approach enables healthcare providers to actively manage

clinical governance programs, with regulators monitoring at arms-length (Balding, 2008). This view is supported by Mosley, Megginson and Pietri (2005), who explained that hospital policy development typically originates from a downward approach to formalise regulatory and accreditation standards, while other key areas relating to safe clinical practice originate from an upward or downward approach. Importantly, though, the problem that this study sets out to address remains relevant even when proceeding towards the implementation of the NSQHSS second edition, as the problem of tension between policy and nursing practice still exists and remains largely unacknowledged.

2.8 Safety, Quality and Policy

The term 'quality' is used broadly in healthcare by external and regulatory bodies (to manage standards of care), consumers (to raise their expectations of high quality) and organisations and healthcare professionals (Organisation for Economic Co-operation and Development [OECD], 2015). Despite this, there remains considerable uncertainty about which policies work best in helping to deliver safe and high-quality care (OECD, 2015). According to the OECD (2015), 1,046 clinical practice guidelines (CPGs) were published in Australia from 1995 - 2013, with 22% developed and funded by government bodies and only 11% containing full systematic literature reviews. Of the 1,046 CPGs, only 14% documented any consumer engagement. The OECD (2015) argued that the extent to which CPGs contribute to quality of care is unknown, and the extent to which individual hospitals and services use or monitor their utilisation and efficacy is also largely unknown. Further, the ACSQHC (2011) identified competing CPGs, which can lead to conflicting recommendations given for the same condition. The quality debate highlights emerging approaches from quality control and assurance through to quality management, continuous quality improvement and total quality management. The OECD (2015, p. 82) stated that:

> "the complexity of Australia's health system continues to pose considerable challenges, in jurisdictional responsibilities and continuity of care, and inconsistency in national measurement of quality remains an impediment to improvement of safety and high-quality of care".

Donabedian (1966, 2005) used a systems approach to define quality, and this model has been widely used in applying concepts of structure (organisation, buildings, equipment, staffing), process (interactions between those who receive services and those who provide them) and outcome (results achieved). This approach continues to be used and integrated into management functions and quality improvement models globally, in regard to the type of metrics considered to measure the outcome of a policy (AHRQ, 2011; Raleigh & Foot, 2010). The premise that policy outcomes can be measured from a structure, process and/or outcome perspective emphasises the importance of understanding the underlying theory and approaches to quality management. For example, outcome measures reflect the effect on the patient, process measures reflect the way the systems and processes work to deliver the outcome, and structure measures reflect the attributes of the service or provider (e.g., resourcing) (AHRQ, 2011; Raleigh & Foot, 2010). This model helps to build appropriate metrics into the policy development, implementation and evaluation processes (Groene, Botje, Sunol, Lopez, & Wagner, 2013).

While this quality model underpins most clinical governance programs today, the evidence of measures that follow the path of structure, process and outcome for particular clinical practice areas is challenging and not well documented or reported. A review of 18 studies that evaluated the implementation of hospital quality management systems found that only a few studies explicitly linked quality management to health outcomes (Groene et al., 2013). The authors attributed the paucity of linkages to the complexity of quality management systems related to specific clinical and quality activities, including policy processes, for which it is difficult to establish causal links to patient outcomes. In most studies, there was:

> "the assumption that enforcing a certain quality management policy and activity will lead to the desired effect, while ignoring the context that shapes the uptake, implementation and effectiveness of the very quality management interventions". (Groene et al., 2013, pp. 538–539)

This was congruent with an analysis of the causes of adverse events reported in the Quality in Australian Health Care study, a seminal piece of work in quality and safety in Australia undertaken by Wilson, Harrison, Gibberd and Hamilton (1999). Of the 2,613 identified preventative strategies that could have avoided or reduced the probability of patient harm, 20.9% were attributed to new or better procedures or protocols and improved availability of these at the point of care (Groene et al., 2013).

The quality problem can be better understood in terms of people not managing, or not knowing how to manage, the complex systems in which care occurs and that they were part of (Harnett et al., 2005). Hospital policies are available in hard and soft copy format with variable version control and access, which poses further challenges for healthcare professionals to know what to do (Scott et al., 2003). The challenge of knowledge and practice is supported anecdotally by nurses, who find that there are too many policies and procedures, they are difficult to access on a computer or in hard copy, and it is difficult to find time to review them among the business and messiness of every day nursing practice.

According to Braithwaite and Westbrook (1992), well-defined policies, procedures and organisational charts should be used to assist in the interpretation of quality management data and to evaluate the degree to which standards have been achieved. The authors argued that if evaluations identify real or potential problems, then actions need to be defined and implemented, which requires changes in policies and/or procedures or the implementation of education programs. Accreditation programs are a core strategy used by governments to ensure compliance with organisational and clinical standards, and policy plays a key role in leveraging this process

(Greenfield et al., 2013, 2015; Greenfield, Pawsey, & Braithwaite, 2012). Regardless of the actions defined and implemented, re-evaluation of the standards is flagged to determine whether the change has taken place; otherwise, the full quality process has not occurred. However, in practice, the regulator reports and evaluation processes reviewed in the reported by Braithwaite and Westbrook (1992) rarely provided evidence of an evaluation that linked policies and procedures to practice and then patient outcomes or experience. Rather, it was assumed that if evidence-based policies and procedures were in place, practice and outcomes would follow, and if the results improved, it could be assumed that the practice and policy were effective.

Turner and Hartley (1998) conducted a study on the status of total quality management in Australian public health organisations. They measured the outcomes of policy and reported that quality managers demonstrated a poor understanding of the theoretical basis and knowledge of this area of healthcare management, and senior management had limited engagement. This problem was reflected in the knowledge and skills of the staff who developed the policies, the implementation process and the design for the evaluation of outcomes. The lack of senior management influence to implement total quality management was observed in larger, more complex organisations. This occurred as a result of senior management not having a direct effect on change, and it was less likely to occur in smaller organisations (Turner & Hartley, 1998). This emphasises the need for varied leadership approaches, as well as the level of difficulty involved in achieving major change in a complex cultural environment such as a hospital. Turner and Hartley (1998) emphasised the need to embed middle and frontline leadership and develop management in healthcare organisations to effectively drive change and quality improvement.

Maxwell, Graudins and Kaye (2006) proposed quality improvement models to address gaps in healthcare by improving outcomes using evidence-based medicine and best clinical practice. Scott (2009) further argued that clinical practice interventions that are evidence-based should be encouraged, and decision-making by managers should actively seek to locate and translate evidence into performance enhancement. CPGs, protocols and pathways were promoted

by Scott, Buckmaster & Harvey (2003) as a way to standardise clinical practice based on evidence and best-practice standards. However, the integration of CPGs into practice was described as problematic due to a lack of awareness of the guidelines and how to access them, disagreement with the guidelines, difficult implementation of the guidelines, and format of the guidelines being too inflexible to individualise them to patients (Scott, Buckmaster & Harvey, 2003). This raises further challenges for the regulatory requirements regarding ease of access for policies and procedures in hospital settings.

In Ryan et al.'s (2017) study on nurses' perceptions of quality of care, hospital policies and procedures were found to significantly influence the quality of services delivered and patient safety. Thus, organisations need to implement policies that encourage nurses to provide quality services in addition to upholding the essence of patient safety. Ryan et al. (2017) reported that nurses believe that providing high-quality healthcare services is the primary goal of nursing practice. According to the Occupational Safety and Health Administration (OSHA, 2018), adopting a patient safety culture is integral to protect both patients and healthcare workers from harm. Essentially, a patient safety culture in the healthcare environment involves acknowledging high-risk characteristics of the organisation's processes and the commitment to consistently achieve safe operations (White et al., 2015).

Medical errors account for harm to tens of thousands of patients in the US population annually (Edvardsson, Watt, & Pearce, 2017). The need to improve patient safety is a matter of priority because of the detrimental effects of medical errors. In this respect, Borrott et al. (2017) reported that effective strategies for communicating patient safety policies need to be implemented in organisations to reduce cases of medical errors among other factors that influence patient safety. A culture of patient safety also focuses on the cultivation of a blame-free healthcare environment by encouraging professionals to report near misses or errors without fear of punishment or reprimand (Borrott et al., 2017).

According to Kaplan, Orris and Machi (2009), the need to establish policies that facilitate the redesign of care systems is one of the key strategies needed to mitigate medical errors and thereby save at least 100,000 lives annually in the US. The redesign of procedures and processes would encourage healthcare workers to report instances of near misses or medical errors that may jeopardise patients' wellbeing (Brady, Malone, & Fleming, 2009). For example, omission errors can occur in nursing practice when clinicians schedule medication dosages incorrectly. Such omissions should be reported to prevent the adversity of the medication error and thus safeguard the patient from harm (Borrott et al., 2017). Therefore, the creation of a supportive clinical environment that upholds the reporting of medical errors without fear of punishment will create a culture of patient safety in contemporary healthcare environments. This approach also emphasises the need for effective health data analytics to provide visibility and analysis of meaningful areas for quality improvement. The challenge of encouraging nurses to report clinical errors that may also highlight policy non-adherence or non-compliance has not been addressed in the literature to date, but it is an area of interest within the aims of this study.

The creation of synergies in policies and procedures in order to enhance the safety of both patients and healthcare workers is an important approach in the development of a safety culture in the healthcare setting (Riehle, Braun, & Hafiz, 2013). Further, units or departments in hospitals need to collaborate to identify factors that undermine patient safety before identifying the relevant interventions that will promote safety in the healthcare environment (White et al., 2015). Communication regarding hospital policy and procedures plays a significant role in reducing incidents of patient harm and healthcare workers' work-related injuries and illnesses (Rees et al., 2017).

Communication has also been identified as a significant contributing factor in adverse clinical events in various sentinel events reports at the state and national levels in Australia (Queensland Health, 2012). Good communication practices promote patient safety by reducing errors in various clinical processes (Gluyas, 2015; Merlino, 2017; Riley, 2016). Conversely, poor

communication increases the chances of erratic medical procedures and inhibits the sharing of knowledge in the case of interdisciplinary communication (Riley, 2016). The participation of the entire workforce in the hospital setting to improve safety standards through policy implementation may improve the culture of safety through policy and effective communication.

System analysis focuses on detailing complexity (many variables) in a linear pattern and understanding the inter-relationships of systems thinking; as a result, cause-and-effect chains and processes of change can be overlooked (Hollnagel, 2014). It was further argued that there are many myths that make RCA problematic, including:

> "providing a definite answer rules out any alternative explanation or event motivation to search for second stories". (Hollnagel, 2014. pp. 85–86)

Hollnagel (2014, p. 87) described that myth is:

> "a belief in compliance"

and that:

> "systems will be safe if people stick to the procedures".

The RCA approach is typified in Hollnagel's (2014) Safety—I perspectives. In this thesis, Safety I refers to a way of thinking whereby adverse events occur as a result of failures and malfunctions of components of a system (e.g., nurses, procedures, technology). Further, rather than trying to expose such myths, they should be examined with fresh eyes. This is the beginning of an exploration into Hollnagel's (2014) Safety—II perspectives. In this thesis, Safety II refers to a way of thinking whereby health practitioners try to understand the majority of clinical practice areas where patient outcomes are positive and understand that nurses are constantly adjusting what they do in their practice so that it matches the current conditions. These perspectives focus on understanding the complexity and many explanations of adverse events (Hollnagel, Wears, & Braithwaite, 2015).

Senge (1990) argued that reality comprises circles of causality or influence, and there is growth in seeking repeating patterns as a reflection of the quality and policy cycles. This understanding of causality and complexity is reflected in the way Hollnagel (2014) challenged the efficacy of the cause-and-effect relationship of system analysis within complex adaptive systems and the effect of human factors on further increasing complexity. Hollnagel (2014, p. 44) further described how

> "emergency surgery on a fractured neck of femur involves a mere 75 guidelines and policies. But even that is far too many".

In this sense, healthcare professionals are expected to behave as they have been taught to, and to believe that there is a perfect match between the policies or procedures and the reality of practice. This has been termed as 'work as imagined' (in this thesis, 'work as imagined' refers to an idealised view of how tasks are performed, as reflected in policy or procedure documentation), which describes the way policies are written as the policy-writer imagines the work should be performed or practiced (Hollnagel, 2014, p. 45; Hollnagel, Wears, & Braithwaite, 2015). In contrast, 'work as done' (in this thesis, 'work as done' refers to the actual way that work is performed, as it unfolds over time and in a complex situation such as nursing practice), which Hollnagel (2014, pp. 40–41) and Hollnagel, Wears and Braithwaite (2015) described as the reality for frontline workers who continually adjust what they do in any given situation to ensure safe practice. This introduces concepts that challenge the simplicity of linear cause-and-effect and system reviews, as health has previously understood, and argues for a different kind of understanding of the complexity of every day clinical practice. The descriptions of Hollnagel (2014) and Hollnagel, Wears and Braithwaite (2015) are consistent with Iedema et al. (2014), who referred to the complexity that lives in situ in the everyday practice of healthcare professionals at the frontline, and which affects policy implementation.

2.9 Policy Implementation

Our values and ideological views influence how we view policy in general and health policy specifically, whereby stakeholders exercise their social agency to contest, respond to and make meaning of policy (Hancock, 1999). Policy implementation is mostly viewed as a downward approach that separates the functions of development and implementation (Ham & Hill, 1984). However, in reality, policy development and implementation are highly inter-related and a source for further study. A paradox exists whereby there is a general consensus that putting evidence into practice is the way forward to improve safety and quality in healthcare (ACSQHC, 2018a). However, there are many barriers to achieving safer practice, and a change in emphasis has moved the concept of improving the quality of healthcare as a general aim to an absolute imperative—in particular, to manage adverse events and reduce patient harm (Sorensen et al., 2009). Health policy in Australia supports an evidence-based model for clinical care as a means to improve quality, and it favours scientific and technical approaches as reflected in evidence-based guidelines and clinical pathways (Lovell et al., 2013). According to Sorensen et al. (2005), bridging the gap between evidence and practice is complex and contested. Rational decision-making models are not applicable in all cases; in particular, complex cases with uncertain outcomes and pathways are viewed by many as political documents used to drive productivity rather than quality (Harnett, Van Kenenade, Lloyd, & Sorensen, 2005). Evidence-based approaches are researcher-led in order to solve problems from the perspective of knowledge generation. However, policymakers are concerned with practical issues that require immediate resolution; thus, the nature of the problem may be quite different, and research can fail to influence health policy (Black, 2001).

Policy decisions are contested at each level of the organisation, and this contributes to the inherent difficulties and frustrations in the lack of effectiveness of policy development and implementation (OECD, 2013). The OECD (2013) explained this by describing a model for policy change that has stable system parameters, external system events, constraints and

resources of subsystem actors, and a policy subsystem that includes staff with different policy beliefs and resources, decision-making by managers, outputs and impacts of policy. Processes are continually changing to meet circumstances; therefore, policy processes change over time and across places (Davis, Wanna, Warhurst, & Weller, 1993). This is how policy is said to proceed by increment; thus, the test of good policy is not about rationality but acceptability, and not about whether nurses think a policy makes sense, but whether they accept the policy and use it in their practice. Incrementalism permits continuous modifications of policy to accommodate new values and stakeholders. It is argued to produce more substantive and lasting change, and it is consistent with concepts of continuous quality improvement (Davis et al., 1993). This incremental change emphasises the role of nurses in providing feedback on policy, effecting its change to be better aligned to practice, and being involved in its continuous improvement. Whether this is observed in practice is a source of further inquiry in this thesis. The literature infers that policy is aligned to a living document and is open to change and progression with active stakeholder engagement, an assumption to be tested in further research.

Ham and Hill (1993) argued that it is important to make policy unambiguous, minimise links in the implementation chain, avoid outside influences and control stakeholders who try to implement policy. Issues around rational logic, clarity and accessibility of policy were also highlighted as key areas to address to increase implementation (Atun, Jongh, Secci, Ohirir, & Adeyi, 2010; Bero et al., 1998; Dobbins, Ciliska, Cockerill, Barnsley, & Di Censo, 2002; Grimshaw et al., 2001; Niessen, Grijseels, & Rutten, 2000; OECD, 2013). Ham and Hill (1993) stated that the implementation stage of policy is often when the real effects of decisions become evident, and when policy is further shaped by the competing interests and practicalities of implementation that require renegotiation and compromise with stakeholders. Implementation has been flagged as the most demanding aspect of the policy process because of the failure to anticipate opposition to policy or the lack of resources required for implementation (Ham & Hill, 1993). Thus, Ham and Hill (1993) argued that, ideally, evaluation should be incorporated into

the implementation process to facilitate both the implementation process and the policy outcome evaluation.

Bail, Cook, Gardner and Grealish (2009) identified that the knowledge and skills of the people who develop policies is an important factor contributing to strong policy development, particularly in cases where the explicit value of frontline nurses' clinical judgement and autonomy is privileged. However, few studies have defined the required knowledge and skills, as well as the effect on outcomes (Bail, Cook, Gardner, & Grealish, 2009). Further research should examine knowledge of context, analytic skills to frame problems, appraised research evidence, predicted outcomes of policy choice, evaluation of risks, writing, drafting, evaluation, program management, communication skills, information technology use, flexibility and innovation (Grimshaw et al., 2001).

Whether or not local practices can translate into policies emphasises that the relationship between policy and practice is inconstant. Wensing and Grol (2019) described the struggle that exists globally in implementing evidence into practice, and both rapid uptake of high-value clinical procedures is needed alongside stopping practices that no longer have value. As such, a policy is not effective as a static document developed at a point in time if it is inaccessible or irrelevant to the stakeholders who need to work within its guidance. The hospital setting is one in which the relationship between policy and practice is continually subject to change, renewal, review, revocation and revision. It has been a challenge for stakeholders to maintain currency with policies and practice in a dynamic setting that is constantly subject to competing influences on behaviour operating in complex adaptive systems that change and adapt (Atun et al., 2010; Plsek & Greenhalgh 2001). This is also reflected in Reason's (2004) active failure and latent conditions argument; as these interactions in health are dynamic and non-linear, they can lead to unpredictable system responses with unintended consequences. Wensing and Grol (2019) advocated implementation science as an approach to promote the systematic uptake of evidence into routine nursing practice and thereby improve quality of care, with knowledge translation

used as a method to enhance the use and usefulness of research evidence. This reinforces the need to consider complexity in healthcare in nurses' every day working lives, as well as the need to understand the effect of this context on the relationship between hospital policy and nursing practice.

Atun et al. (2010) suggested that the collective perceptions of all stakeholders determine how interventions are received. The authors argued that health innovations are gradually adopted from cumulative and unpredictable translation processes over time and at different levels of the system. They align with regulatory mechanisms and are integrated into reporting frameworks. Technological change and critical events in the organisation can provide opportunities for more rapid adoption of interventions into health systems—for example, through system review recommendations. The significance of local workplace culture and change processes reflects the need to consider these factors in the relationship between policy and nursing practice to understand further during this research study.

System views of healthcare repeatedly introduce the problem of distractions for clinicians within a complex adaptive system, which may be difficult to control and proceduralise. This problem of controlling and proceduralising is reflected in the constant realisation that, regardless of how well a policy or procedure is formulated, it cannot guarantee that it will alert clinicians to the need for heedfulness of the complexity of clinical situations and the unpredictable environmental, personal and workplace distractions or contributing factors (Reason, 2000, 2004). In this thesis, 'heedfulness' refers to a nurse's trait of staying aware, being mindful in their practice, routinely preparing for potential challenges and thinking about potential solutions. The argument espoused by Reason (2004) through his explanations of error wisdom, whereby clinicians develop skills to compensate for errors that are part of their daily practice, shows that the complexity of clinical work goes beyond what individuals can know and what can be formalised through policies and procedures. In this thesis, 'error wisdom' refers to a nurse's awareness of the likelihood that something may go wrong. Policies then remain subsidiary to the

richness and complexity of daily clinical practice (Iedema et al., 2005). In this sense, hospital policies may not reflect current nursing practices because they may become outdated or may not be actively monitored or enforced. The presence of a policy, irrespective of how explicit it is or the extent of staff training, does not guarantee that staff will follow it (Iedema et al., 2005). A review of the literature on hospital policy and its relationship with nursing practice found that limited statistical material has been reported on policy outcomes, and there is little evidence linking health inputs to outcomes and consumer satisfaction.

Taft and Nanna (2008) found that the primary driver of nurses' low rate of involvement in policy processes is their lack of knowledge and skills to influence policy formulation. The authors asserted that most nurses are not aware of or involved in health policy issues. They proposed that in knowing a policy's source, a nurse can improve their understanding of the policy and thereby enhance their ability to change it with a particular impact, most likely in micro-policies, within an organisational policy context. This makes broad assumptions about the generalisability of motivation and the aptitude of individual nurses to be driven to this level of engagement or active participation without reference to empirical evidence to support their proposition. Benner's (1982) novice to expert conceptualisation of nursing skills and experience further challenged the premise of the generalisability of all nurses in terms of motivation and aptitude, as well as the level of engagement as it relates to policy knowledge and application. These arguments make an assumption that the workload of and resourcing for frontline nurses supports active involvement and engagement in policy processes.

Policy is contextual in its development and remains contextual in its implementation and evaluation because the health systems in which these policies exist are complex, dynamic and do not operate in a linear fashion (Iedema et al., 2005). The implication of complexity operating in healthcare is that policy development and enactment are not straightforward but subject to the changes and pressures of every day nursing practice. There is limited reference to hospital policy implementation and evaluation in the literature. However, Grimshaw et al. (2001) advocated for

identifying barriers, improving capacity for piloting and demonstration, strengthening processes for monitoring and adjustment of incremental policy development and implementation, and involving implementation managers in policy development. Bridging the research–practice gap by implementing research-based evidence and CPGs would provide a useful body of transferable knowledge to consider. The implementation of evidence-based approaches, policy implementation and evaluation were described by Grimshaw et al. (2001) as the key areas to link and integrate.

Policy is not a key part of nursing education as a pedagogical approach; thus, knowing how policy awareness can be integrated into clinical practice is not always clear to nurses, and issues around policy engagement are complex and dynamic (Malone, 2005). The duality of the individual and local focus of nursing education was described by Malone (2005), with in-situ nursing practice dominating despite the role of policy in shaping physical and social aspects of clinical care. Further, Malone (2005) asserted that it is unrealistic to expect all nurses to be policy experts to perform good patient care, or to be policy activists. In emphasising the complexities of frontline clinical practice, a model was proposed by Malone (2005) to assess policy environments to better understand the issues around policy engagement. The importance of nursing leadership in advancing evidence-based policy change is a leadership challenge that nurses should embrace, with nursing advocacy as a foundational principle of all nursing practice (Garrett, 2018). In this sense, understanding the policy and practice environment is an important aspect of implementation and change management for policy at the frontline and organisational levels. Policy remains subsidiary to the richness and complexity of daily clinical practice and local workplace culture.

2.10 Culture, Change and Policy

Hackett et al. (1999) described the importance of culture through effective clinical governance frameworks that deal with the leadership of changes and management of power

networks across the system. The authors argued that senior management needs to constantly measure and analyse the interactions between culture, power and leadership to facilitate change that is accepted by all stakeholders (Hackett et al., 1999). Local workplace cultures need to be considered in this context. These subcultures, reflected through informal workplace discourse, refer to the cohesiveness of relationships, and they facilitate underlying efforts to make progress or effect changes (Braithwaite, 2004). Thus, the policy process can be viewed as a process of organisational change (Pettigrew, 1990), and given that change is often rapid and planned to varying degrees, it has been described as complex (Iedema, Mesman, & Caroll, 2013).

Understanding the significance of workplace culture in the context of clinical governance is an area of increasing study. Braithwaite (2004) and Hackett, Lilford and Jordan (1999) emphasised cultural change, in which these drivers become common themes for consideration as potential barriers to effective policy implementation, reflecting that these concepts have changed little over time. Based on Rogers' (1983) work on diffusion, Ferlie and Shortell (2001) outlined diffusion of innovation for change in terms of attitude to innovation in the micro, meso and macro systems in which the organisation is embedded. However, DiBella, Nevis, Edwin and Gould (1998) argued that focusing on individuals through education or dissemination of documents such as policies does not have a significant effect on improving quality. Given that teams deliver most healthcare, they can be a powerful lever for change because they are the basis of micro systems in health for focusing on clinical quality improvement. Adaptive strategic change has been advocated for health systems (Ferlie & Shortell, 2001). Use of the organisation as a lever for change is based on its culture for change through existing operating systems. The extent to which the organisation is a learning organisation can affect adaptability to rapid change and the implementation of quality improvements and policies (Senge, 1990). If policies and procedures are viewed as living documents that can change and be updated based on lessons learned over time, then rapid change can occur based on what is happening in practice, and in a way that makes sense to frontline nurses. However, the rate of change of practice may outstrip

the rate of change of policy. In this sense, whether policies can match the pace of change and the context of every day nursing practice is a source of consideration in this research study.

Policies that bring about change in the hospital environment influence the perceptions of nurses in integrating them into new practices or stopping old practices. Resistance to change may develop from some members, resulting in adverse effects on the organisation (Singh, 2009). A disruptive working environment may emerge as a result of the introduction of new ideas into an organisation's operations. Singh (2009) argued that issues may arise when members are pessimistic and sceptical about the integration of innovations into operating room procedures. Therefore, hospital management should anticipate a disruptive working environment as a negative result of change. In this sense, various factors may hinder nurses and other healthcare professionals from implementing policies that aim to bring about organisational change. A study conducted by Scully (2015) revealed that effective change management in nursing practice calls for the change agent to consider nurses' attitudes in relation to the outcomes of engaging or not engaging in that particular change, as well as the incentives put in place to ensure the individual shows their appreciation and support for the desired change. Similarly, Finkelman and Finkelman (2012) argued that hospitals should provide information to employees based on their characteristics and personal understanding of risks when the individual feels they will be affected by the change. The organisation's policies should be precise regarding the conditions of the change, enable the individual to understand when to take the necessary action and provide the individual with the resources necessary to address the consequences or mitigate the effects of the change (Cummings, Fraser, & Tarlier, 2003). Fixen, Naoom, Blasé, Friedman and Wallace (2005) referred to the use of implementation science in a similar approach by using specific, observable actions and methods with reliability using evidence-based programs in education settings to achieve sustainable and positive change and outcomes. The implementation framework was detailed by Blasé, Fixen, Sims and Ward (2009) as a five-stage process involving usable interventions, implementation stages, implementation drivers, improvement

cycles and implementation teams to support change and adaptive challenging in order to succeed in implementing evidence into policy and practice.

Policies that promote continuous organisational change in the health sector can take many forms that have direct implications for clinicians (Grealish & Smale, 2011). To ensure the effective adoption of new ideas communicated in key policies, the motivation of members of the organisation is crucial (Demers, 2007). Maintaining open communication with clinicians is an effective method of motivation (Grealish & Smale, 2011). It fosters transparency and inspires members of the organisation to accept new policies that affect existing systems (Stanton, Young, Bartram, & Leggat, 2010). Negative rumours about innovations that may harm workplace morale can be mitigated through the effective communication of hospital policies (Palmer, Dunford, & Akin, 2008). The facilitation of learning for motivated members of an organisation to accept and implement new ideas in their operations and the provision of training on the importance of organisational change is not adequate for the effective adoption of continuous change (Sayers & DiGiacomo, 2010). This ineffective change outcome may contribute to what is considered an evidence–practice gap, whereby evidence-based practice is generally accepted but is difficult to implement effectively with hospital policy alone.

2.11 Evidence–Practice Gap

The contemporary nursing environment underlines the need for professionals to observe evidence-based practice as a way to improve the quality of healthcare provision. In this respect, hospitals in Australia have prioritised the creation of policies and procedures that generate the necessary knowledge to influence nurses to adopt evidence-based approaches when providing services to patients. The most effective dissemination strategies for putting research evidence into practice have been detailed in the literature, with culture highlighted as the key influential factor on the uptake of innovations, along with the value that the organisation placed on using research evidence (Cleary et al., 2018; Zimmerman, Lindberg, & Plsek, 2008). Passive

dissemination is not considered effective, and using specific strategies to encourage the implementation of research evidence to consistently ensure change in practice is advocated by Zimmerman, Lindberg and Plsek (2008). Consideration of the target audience's beliefs and attitudes, knowledge of clinical professions, local and organisational context, priorities, and commitment of stakeholders are important in understanding barriers to optimal implementation (Zimmerman, Lindberg, & Plsek, 2008). Making policy unambiguous, minimising links in the implementation chain, avoiding outside influences and controlling stakeholders who try to over-implement are important in policy uptake by nurses (Ham & Hill, 1993). Issues around rational logic, clarity and accessibility of policy are also key areas to address to increase implementation (Atun et al., 2010; Bero et al., 1998; Dobbins et al., 2002; Grimshaw et al., 2001; Niessen, Grijseels, & Rutten, 2000).

A study conducted by Squires, Moralejo and LeFort (2007) sought to investigate the degree to which nurses refer to the policies and procedures established by hospital management to guide their practice, especially in evidence-based areas. The results of the study revealed that nurses considered the policy and procedure manual the top source of practice knowledge (Squires, Moralejo, & LeFort, 2007). Nurses mainly consulted the policy and procedure manual to ensure they practiced in line with the established agency rules (Squires, Moralejo, & LeFort, 2007). A significant group of nurses identified organisational policies and protocols and personal experience as the leading formal sources of knowledge facilitating evidence-based practice. In this light, nursing professionals rank policies and procedures, as well as personal experience, as the most important resources that facilitate the application of evidence-based approaches in the process of delivering services to patients (Malik, McKenna, & Plummer, 2015).

An array of factors undermines the effectiveness and efficiency of hospital policies and procedures, which aim to encourage nurses to embrace evidence-based practice. According to Baatiema et al. (2017), these factors include poor organisational support, low level of awareness, limited skills and competence of healthcare practitioners, and little confidence in or familiarity

with the effectiveness of a given evidence-based therapy. Saunders and Vehviläinen-Julkunen (2016) found that low management support in hospital environments undermines nurses' observations of relevant policies and procedures, leading to poor integration of evidence-based approaches in the nursing field. Most importantly, the application of knowledge transformation strategies such as the clarification of policies and procedures is needed to foster the readiness of nurses to adopt evidence-based practice (Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014). Further, nurses consider their evidence-based practice knowledge and skills inadequate to facilitate the adoption of the best evidence-based practice (Saunders & Vehviläinen-Julkunen, 2016). Additionally, Baatiema et al. (2017) emphasised that management teams in hospital settings should create and execute policies and procedures that enhance peer support within the healthcare communities of practice. Thus, management support is important for the successful implementation of policies and procedures in hospitals that aim to guide nurses towards the absorption of evidence-based practice (Baatiema et al., 2017).

Overall, the reinforcement of hospital policy is an important strategy in fostering the adoption of evidence-based practice in various healthcare institutions around the world. One study uncovered that it is crucial for hospital management to adopt policies that address barriers to the use of research and evidence-based practice (Stavor, Zedreck-Gonzalez, & Hoffmann, 2017). Policies fostering the provision of education towards the process of research was identified, besides offering supportive monitoring at the time of implementation that had the potential of increasing nurse's adoption of evidence-based practice to 90% by 2020 (Stavor et al., 2017). In a similar study, Skela-Savič, Hvalič-Touzery and Pesjak (2017) argued that hospitals need to establish educational policies that focus on training healthcare professionals to enhance their knowledge and skills regarding the implementation of evidence-based approaches in their respective areas of specialisation. In this view, training is considered a major policy measure that will increase the implementation of evidence-based practice by nursing professionals in contemporary healthcare environments. However, Carter, Mastro, Vose, Rivera

and Larson (2017) argued that the training of healthcare professionals is not an adequate measure of fostering the effectiveness of hospital policies and procedures using evidence-based practice. Thus, the authors considered clinician–researcher collaborations a key strategy in improving nurses' engagement in evidence-based practice (Carter et al., 2017). The knowledge gap regarding evidence-based practice requires hospitals to consider implementing policies that foster education and research to develop the knowledge and skills of nurses and other healthcare professionals. The role of managers in promoting policy processes for frontline nurses is therefore critical for uptake by nurses into practice, or perceptions of rhetoric and managerialism if policy is seen to be used for punitive or compliance purposes only (Carter et al., 2017).

2.12 Policy Rhetoric and Managerialism

As part of the overall literature review, 28 articles from international sources were reviewed that related to hospital policies. These were categorised under policy rhetoric and managerialism. In the context of this thesis, policy rhetoric is the heuristic for understanding the persuasive communication around policy by regulators and managers, whereby it initially appears that there is no problem with policy other than clinicians not following it. This is further understood in Carlisle's (2011) description of managerialism of healthcare systems, which is a good example of hierarchical top–down command and control management styles that focus on achieving efficiency and control through the cascading of well-defined top–down objectives. Quality programs work most effectively when downward approaches meet upward approaches, and with staff involvement at each level of the organisation. In theory, this approach enables healthcare providers to actively manage clinical governance programs with regulators monitoring at arms-length (Carlisle, 2011). The predominance of the downward policy approach in hospital settings to demonstrate compliance supports a bimodal approach to policy adherence or non-adherence that is overly simplistic in healthcare delivery and in a complex setting such as a hospital (Anuobie et al., 2015; Azeez–Akande, 2012; Fonseca, Ramos, Santos, & Fonseca, 2015; Kneafsey, Clifford, & Greenfield, 2015; Seale, Kaur, & MacIntyre, 2012). The degree of

success of policy implementation in these studies was attributed to the limited data that were captured to measure patient outcomes and incongruent resourcing to ensure effective implementation in areas of 24/7 service provision in terms of education, staffing, monitoring and other resourcing for effective and sustainable policy implementation.

Further, the complex nature of healthcare systems means that the emergence of self-organising structures and nursing workarounds are a natural part of healthcare systems, similar to all complex living systems, which adapt to changes minute by minute. This means that we cannot fully foresee what will happen in the future, and applying solutions from the past will not always work (Carlisle, 2011). To understand this theme further, literature was drawn upon from a range of international authors in order to place the theme within the context of the worldview. Complexity plays a role in hospitals, and the emergence of practice and the inter-connectivity of people and processes is inevitable in such complex adaptive systems (Carlisle, 2011; Kneafsey et al., 2015; Linder, Siebens, Mueller, Gibbs, & Freeman, 2017; Sadsad, Sintchenko, McDonnell, & Gilbert, 2013). These authors also argued that where hospital policy and nursing practice are concerned, a bimodal understanding is insufficient to explain what occurs in every day nursing practice. Further, coherent and incremental policy implementation and change within distributed decision-making networks is more likely to be effective in engaging frontline clinical stakeholders (Junger et al., 2014). Kulshetha, Mathes, Kapddia and Sanwatsarkar (2013) emphasised that many areas in nursing practice are not covered by policy and procedure, and they described the importance of embracing bottom–up drivers for policy that nurses at the frontline view as important and necessary, and subject to potentially greater sustainable implementation and embedding into practice. Professional organisational policy statements as an effective guide to developing hospital policies in specialist areas are used in some hospitals. For example, the Australian College of Perioperative Nurses has been pivotal in developing and influencing guidelines and standards, such as the Standards for Perioperative Nursing in

Australian, which have been adopted into hospital policy and practice through active nursing membership and engagement (Australian College of Perioperative Nurses, 2018).

In complex systems such as hospitals, unpredictability has always been evident, and organisational functions are interdependent, self-adjusting and constantly interacting in a paradigm of dynamic complexity (Plsek & Greenhalgh 2001). Effective policy implementation depends on a number of successful links in an organisational chain. The degree of cooperation between these linkages must be high to prevent small deficits cumulatively becoming a large shortfall. Symbolic policy may exist where there may be no intention to implement; however, the policy may be effective in giving the impression that the organisation is taking action. The policy may maintain the support of senior management, but it may not, for various reasons, find support in terms of priorities and actions. There is danger in this approach in terms of implementation of standards through policy processes with a reliance on self-regulation (Hogwood & Gunn, 1984).

2.13 Summary of Gaps and Key Areas for Further Investigation

Gaps in knowledge and key areas for further investigation have been revealed in the literature review to justify the direction of this research. The keys considerations are outlined below:

- Tension exists between what is required from a regulatory perspective and what is actually practiced in the management and provision of healthcare to patients in the everyday work of nurses;
- The knowledge gap regarding evidence-based practice requires hospitals to consider implementing policies that foster education and research to develop the knowledge and skills of nurses and other healthcare professionals;
- The integration of CPGs into practice is problematic as a result of the lack of awareness of guidelines or how to access them, disagreement with guidelines, difficult implementation of the guidelines, and format of the guidelines being too inflexible to

individualise them to patients. This further challenges the regulatory requirements for ease of access for policies and procedures in hospital settings;

- Regulator reports and evaluation processes that were reviewed in the reported studies rarely provided evidence of causal links between policies, procedures and practice, and between patient outcomes and experience;
- There is confusion among quality managers in analysing hospital policy and measuring the outcomes of the policy;
- Policies and procedures in the hospital environment are an essential resource for professionals, and especially newly registered nurses, who are unlikely to have developed a wide range of skills, experience and knowledge in all relevant areas of nursing practice;
- A considerable number of healthcare organisations have not implemented best management practices to facilitate the proper implementation of policies and procedures;
- Most hospitals prioritise policy formation and thus leave out the crucial aspect of implementation. Consequently, nurses may fail to observe the required procedures that would improve the quality of care delivery, thereby undermining the reachability of the basic goals of care. This emphasises the problem with focusing on policy formation over implementation, and it affects frontline nursing practice, where the policy may be in place but not entirely synthesised into all nurses' every day practice;
- The novice to expert conceptualisation of nursing skills and experience further challenges the premise of the generalisability of all nurses in terms of motivation and aptitude, as well as level of engagement as it relates to policy knowledge and application;
- There is a gap in the literature relating to electronic policy database development and implementation within Australia, where most published material has been based on paper-based policy manuals;
- There is a gap in policy and practice between frontline nurses in their everyday practice and managers and accreditors;

- Most hospital policies and regulations focus on realising patient outcomes, and there is little concern for the effect on nurses, which hinders the overall improvement of the healthcare system;
- Evidence-based approaches are researcher-led in order to solve problems from the perspective of knowledge generation; however, policymakers are concerned with practical issues that require an immediate resolution. Thus, the nature of the problem may be quite different, and research can fail to influence health policy;
- Policy is aligned to a living document and is open to change and progression with active stakeholder engagement—an assumption to be tested in further research;
- There is a need to consider complexity in healthcare in the everyday working lives of nurses and to understand the effect of this on the relationship between policy and nursing practice;
- Nursing professionals rank policies and procedures and personal experience as the most important resource that facilitates the application of evidence-based approaches in the process of delivering services to patients; and
- Complexity plays a role in hospitals, and the emergence of practice and the inter-connectivity of people and processes is inevitable in complex adaptive systems. Further, where hospital policy and nursing practice are concerned, a bimodal understanding is insufficient to explain what occurs in every day nursing practice.

2.14 Conclusion

This literature review has provided a comprehensive analysis of recent and historical literature from Australia and around the world relating to the research area of policy and nursing practice. This chapter has provided a broad field of reading to assist in understanding the research problem, and it has clarified the aims and objectives of the study.

The gaps and lessons learned from the literature demonstrate the complexity of understanding where policy is positioned in a discussion about nursing practice. To identify a link between policy non-adherence and patient harm, a medico-legal or managerial approach could be used to simplify the discussion and provide an understanding of why nurses do not always follow a documented policy when questioned following an adverse event. However, this narrative is too simple an analysis and does not take into account the complexities of every day nursing practice in a healthcare environment. It also makes many assumptions regarding the system state, structure, processes and culture that are in place. If the system is broken, why does most care proceed without harm so that patients receive their intended care? If nurses do not adhere to policies, why do more patients not experience harm? This research sets out to explore and understand this phenomenon and provide an explanation and recommendations aimed at improving safe and appropriate care for patients.

The literature review has unearthed important aspects of the hospital policy and nursing practice phenomenon. Overall, the Australian health system is regarded as one of the best in the world, thereby denoting that various types of hospital policies and procedures have been embraced by nurses. Nonetheless, the ineffective implementation of policies and procedures in hospitals mainly arises from an inadequate focus on factors that hinder healthcare professionals such as nurses from observing the rules and procedures of the practice. For this reason, evidence-based approaches have not been adopted wholeheartedly by nurses, thereby undermining a high-level realisation of quality care provision and patient safety. Further, the organisational culture affects the extent to which hospital policies and procedures are adopted by nurses, as some nurses resist changes that are incompatible with their preferred values and practices.

Policy is contextual in its development and has remained contextual in its implementation and evaluation because the health systems in which policies exist are complex, dynamic and do not operate in a linear fashion. Health systems are driven by many external and internal drivers, with health reform making regulators and consumers the dominant drivers to improve the quality

of healthcare more efficiently and without causing harm to patients. The system drivers translate into greater transparency and accountability for clinical practice and governance processes, and they contest well-established political, social and cultural norms within the healthcare system.

The literature review has informed the study's aims by identifying what is known about the relationship between hospital policy and nursing practice and forming an understanding of global, national and local views on the phenomenon. The review has established that there is a problem in the relationship between hospital policy and nursing practice, and it has developed an understanding of the literature and the inherent gaps in understanding that support the aims and objectives of this study. The next chapter begins the research journey that has arisen as a result of the expanded knowledge and identification of gaps in knowledge.

Chapter Three: Methodology and Methods—Phase One

3.1 Introduction

The previous chapter reviewed the literature on hospital policy and nursing practice, and it identified gaps to support the aims and objectives of this study. This chapter explains how the data were collected, justifies the qualitative approach used in this study and describes the methods that support this approach. It also describes how the study was conducted and outlines the data collection, management and analysis methods. Further, methodological and theoretical approaches to achieve the study's aims and objectives are presented. The discussion concludes with an outline of ethical considerations, an exploration of the limitations of the study and a summary of reliability and authenticity in the context of the underlying constructivist paradigm. Criteria for credibility, transferability, dependability and confirmability are outlined to help demonstrate reliability and authenticity of the study's findings and analysis (Lincoln & Guba, 1985, 2007).

3.2 Methodology

3.2.1 Qualitative Research

Methodology has been described as the principles that support research approaches and a means for researchers to determine the appropriate methods to collect data for analysis (Carter & Little, 2008). Thus, methodological analysis provides a theoretical understanding of which methods are best suited to address the research questions. The methodology underpinning the study provides an approach to align the theory or ideas and methods used in the research to support the exploration and understanding of the stories and experiences of frontline nurses and their practice relationship with hospital policy (Hesse-Biber & Leavy, 2006; Kramer-Kile, 2012).

Qualitative research in the social world has studied phenomena in healthcare settings, making visible the everyday lives of people in their own social setting, including the meaning

and interpretation of the practices of nurses in their everyday work (Denzin & Lincoln, 2011). Exploring and understanding the perspective of nurses who participate in the study will create a person-centred narrative of what it means to practice nursing within the context of hospital policy. This needs to be expressed through a qualitative research approach, which is considered appropriate in cases where understanding the behaviour of nurses is contingent on understanding the meanings and interpretations given by nurses to those behaviours (Hammersley, 1992).

Qualitative research has been described as necessary and appropriate when the problem being explored enables silenced or disempowered people to speak out and be heard, and this can only be done by speaking with those affected in their natural environment—in this case, nurses in their everyday workplace (Liamputtong, 2010). This approach was chosen to help the researcher explain and understand the nature and complexity of the problem, namely, between nursing practice and hospital policy (Liamputtong, 2010). It is important to understand this qualitative research approach to be able to listen to nurses' accounts of their relationship with hospital policy in the context of a discussion about the epistemology and ontology that has established a foundation and pathway for the research design and approach used in this thesis.

3.3 Epistemology and Ontology—Paradigmatic Approaches

Paradigms are ways of thinking about the world, and particularly about reality and knowledge in the world (Tracy, 2013a). It is important to understand the paradigmatic, epistemological and ontological aspects of the research approach in order to develop a methodology that can explain strategies for collecting and analysing data in a research study (Tracy, 2013a). Epistemology is the knowledge embedded within a theoretical perspective that informs all components of the research process, more simply, it is the nature of knowledge (Hesse-Biber & Leavy, 2006; Tracy, 2013a). Through a qualitative research lens, epistemology provides the context for how the reality of the phenomenon came to be known. There is a relationship is between the knower (researcher and participants) and the known phenomenon,

bound by the various principles and assumptions informing the process of knowing in undertaking the research study (Vasilachis de Gialdino, 2009).

Understanding the epistemological perspective influences the research process at each phase and emphasises that the nature of qualitative research enables the researcher and nurse participants to bring their own assumptions, beliefs and questions to their study, whether knowingly or subconsciously. The nature of knowledge that is sought in this study reflects the clinical governance lens through which the research is being undertaken. The effect of epistemology is that it shapes the researcher's perspective of nurse participants in data collection and analysis. Throughout the study, the researcher aims to engage with nurse participants as an insider–outsider by forming a relationship with them, allowing the unexpected to take place and remaining alert to multiple ways of observing the phenomenon. (In this thesis, 'insider' and 'outsider' refer to the researcher's positioning as a team member inside the organisation with knowledge of many processes and people in the organisation, but also as an outsider to the participant teams being studied and without the complete local knowledge of the processes and people at the ward level.) The insider–outsider approach reflects the membership roles of the researcher in areas of qualitative research, as well as effects on the methodology and methods undertaken, as the researcher plays a direct role in data collection and analysis. The insider aspect of the researcher's role refers to sharing characteristics and experiences with the nurse participants and field sites, whereas the outsider aspect refers to being considered new to the field site and not, or only peripherally, part of the culture or team (Adler & Adler, 1987; Corbin, Dwyer & Buckle, 2009). Thomas, Blacksmith and Reno (2000) emphasised the effectiveness of team configurations with insiders and outsiders because of the variation in experiences of the researcher and the team, which broadens their perspectives and creates maximum advantage of the potential interpretations of behaviours observed in the fieldwork.

Approachability is considered important in engaging with participants in fieldwork in a non-threatening and safe manner (Lofland et al., 2006; Mayorga-Gallo & Hordge-Freeman, 2017). Lofland et al. (2006, p. 41) described entering the field,

"armed with connections, accounts, knowledge and courtesy",

to maximise access to participants and meaningful data. Adu-Ampong and Adams (2019) argued that the positionality of an insider or outsider is important to negotiate throughout the fieldwork, with the researcher aiming to always remain approachable to participants. They emphasised the need for reflection to assist in ongoing negotiations required for research encounters in the field. Subsequently, the researcher will be able to observe the manner in which nurse participants interact, as well as their language and the ways they create meaning about the relationship between hospital policy and nursing practice. This way of thinking about knowledge affects the methods and ways in which data quality is maximised and data sources are triangulated to attempt to maximise accuracy (Carter & Little, 2008).

A fundamental perspective of this study is the role of the researcher as the Regional Safety and Quality Manager and Director of Clinical Governance in the study setting. In this context, the initial idea that a problem exists in the relationship with hospital policy and nursing practice was raised and questioned by the researcher. The relationship between the research and the participants is an important consideration in understanding the researcher's epistemological stance (Creswell, 2007). This approach is reflected in the clinical governance lens through which hospital policy and nursing practice are being considered within the research space. The desire to understand the views and practices of frontline nurses in their everyday work from their own perspective is the key to understanding the nature of knowledge in this study. Based on the researcher's day-to-day experiences, managerial and other perspectives are often reflected in internal and external reporting and associated narratives, but the experience or perspective of frontline nurses regarding hospital policy is rarely considered.

It is difficult for researchers to understand the relationship between truth and knowledge within the research design as being core to the epistemological approach to understand how we come to know the world in which we practice (Denzin & Lincoln, 2011). From this perspective, the researcher has sought to design the research to understand the multiple truths that surround the space involving hospital policy. This requires seeking first-hand accounts from a range of stakeholders involved in caring for patients and managing care and service provision from a nursing practice perspective. This emphasises a constructivist and post-modern paradigm, in which there are many multi-faceted realities to a phenomenon, rather than a positivist position, which privileges a single truth (Tracy, 2013a). Ontology has been described as the nature of reality (Tracy, 2013a). Reality is constructed where social actors, in this case, nurses form interactions and create a reality for the nurses who adopt those practices (Sandu & Unguru, 2017). Constructivism is therefore a crucial piece of the post-modern perspective of negotiating reality (Sandu & Unguru, 2017). This view of constructivism further validates the qualitative research design approach, which seeks to make visible the contested notion of what hospital policy is or is not. Understanding how nurses experience hospital policy in their everyday work is made possible by exploring their voices and experiences, as well as those of the researcher in the role of clinical governance oversight. There is an awareness of personal assumptions and biases, the complexity and multiple viewpoints at work in a healthcare setting, and the journey of understanding different perspectives (Sandu & Unguru, 2017). This consideration provides an opportunity to obtain new knowledge about the phenomenon of hospital policy and nursing practice. This is an important consideration for the research design.

A study on incident reporting highlighted three frames that support the context of how agents such as nurses enact reporting practices. The first frame, formalism, views procedures as playing a central role in referencing change in practice (Rossignol & Hommels, 2017). The central idea of formalism is meanings and practice that use incident reporting systems as an instrument to enhance patient safety through the identification of deviations from procedures.

These deviations may be viewed as deviant practices from some agents, and learning from incidents may mean conforming to practice that reflects the policy or procedural rules (Rossignol & Hommels, 2017). Drupsteen and Guldenmund (2014) emphasised that similar events have the ability to generate different lessons or learnings for organisations, particularly where events and consequences are distinguished. The distinction of events and consequences in learning from incidents is not universally supported. Homsa, van Dyck, Gilder, Koopman and Elfring (2009) emphasised the benefits of learning from near-miss events, which occur more frequently than actual events, because they provide a continuous focus on maintaining safety. The authors also argued that more lessons are learned from catastrophic events than similar errors with negligible consequences for patients. Further, learning that takes place externally to the agents involved, such as management or quality and safety teams in a hospital, may result in the development of new policies and procedures following the review of an incident. However, this has been reported to be resisted by those who do not agree with changing their work practices. In such cases, nurses may challenge the changes based on their own experiences and critical thinking processes (Rossignol & Hommels, 2017). The second frame is being disciplined, in which the risk of being blamed for an incident facilitates actors to follow procedures, and they may learn from their mistakes as a process of self-reflection (Rossignol & Hommels, 2017). The third frame is the sharing of learning through stories about patient incidents and safe practices, and this is considered a dominating frame for actors with the most experience because they collect information in the field over time to build on their knowledge (Rossignol & Hommels, 2017).

The authors argued for an epistemological discrepancy between the three frames, as well as a constructivist perspective in which transparency, reflexivity and situated practice offer greater organisational safety than control and formalism. This view challenges the relational effects of power and knowledge on learning in nursing practice and highlights the distributed voices on the relationship between hospital policy and nursing practice (Burchell, Gordon, & Miller, 1991). In a similar theme, Hollnagel's (2014) perspectives on safety also challenge the

approach of formalism and discipline in effectively improving patient safety. This is relevant to this study, where the 'insider–outsider' researcher roles afford access, trust, entry and some common ground to commence the research, but it also highlights the need to construct methods that facilitate reflexivity to challenge the researcher's assumptions and potential influence on data collection and analysis (Burns, Fenwick, Schmied, & Sheehan, 2012; Corbin, Dwyer & Buckle, 2009).

The understanding and application of these approaches are relevant to the data analysis through different perspectives of the same scenario described by nurse participants. Epistemological approaches focus on how the researcher and nurse participants make sense of the world, or more specifically in this study, make sense of hospital policies (Carter & Little, 2008). Ontological and epistemological approaches are inter-related in helping to understand what hospital policies are (their purpose), as well as their usefulness and application in nursing practice. This raises the consideration that multiple realities and perspectives are inherent in the construction of concepts around how nurses make sense of hospital policies (Carter & Little, 2008). This sense-making is mediated through language and stories that are told and understood by different stakeholders and the researcher. Sense-making reflects a social process that is communicated through the language and stories based on individual nurses' experiences and thought processes (Carter & Little, 2008). Sense-giving reflects the process in which a manager tries to influence and gain support for their construct of reality, which is the result of a sense-making process (Parry, 2003; Weick, 2001). This emphasises the need for a consistent interpretive approach and reflective processes during the research process to ensure the meaningfulness of the study's findings.

Reflective approaches involve trying to understand the narrowness of the researcher's own perspective and seeking alternative viewpoints as an active process. Hermeneutic reflection takes into account the situated nature of knowledge, and the researcher's reflection of their perspective in the process of interpretation is an important contribution to the study perspective

(Walker, 2011). Reflection is a study method in the sense that it is central to support the methodological approach. On this basis, understanding the nature of reality in the study context is important in this ontologically complex study setting (Denzin & Lincoln, 2011). Multiple viewpoints are expected, and the nature of the study will be limited to describing what is observed and understood from the experiences of the nurse participants in the particular study settings regarding their relationship with hospital policy and nursing practice. Reflecting on the nature of reality within the clinical governance lens, and positioning the research within a paradigm such as post-modernism and constructivism in this study, provides an approach to organise the complexity of both epistemological and ontological decisions about the research design (Denzin & Lincoln, 2011).

3.4 Post-Modernism and Constructivism

The central tenets of post-modernism are that realities are constructed within a specific political, historical and social context. These realities are not static but are always being reformed, constructed and deconstructed with no single reality or truth and related knowledge to power relations (Foucault, 1977; Liamputtong, 2010). This approach sets out to deconstruct the meanings that nurse participants make about their everyday experiences and the language they use (Ramaekers, 2006). Each nurse participant has a different story and expression of language to understand what hospital policies mean to them and how they make sense in their healthcare setting. Each understanding is personal and equally valid within the nurses' own context, but it also influences the culture and context for others in that setting. The post-modern approach to power and knowledge relating to policies argues that it is unstable and has many realities, highlighting moments of domination, self-subordination and accentuated resistance and change (Tracy, 2013a). From the researcher's perspective, this infers a shift from being a purely objective 'outsider' or observer to one who is intimately involved in the research as an 'insider'. Further, it emphasises the researcher's involvement as part of the understanding of the world, and one in which the voices of the nurse participants are viewed as the authority to the text and

knowing produced through the research process (Ramaekers, 2006). The tensions highlighted around formalism and power relations between nurses and management are a critical consideration in this space (Rossignol & Hommels, 2017).

The concept that knowledge is constructed from one's actions with their environment is supported in learning by encountering and then exploring a phenomenon and initially attempting to assimilate new information into existing knowledge and ways of thinking (Piaget, 1952). If the participants' understanding of the phenomenon does not match their existing schema, then they are motivated to accommodate it as a new experience, and this is how it is proposed that knowledge is developed. Building on this work, practical wisdom in nursing, or clinical wisdom, has been described as that which is developed with experiential learning in nursing practice over time. This could include discernment of the best way to provide the right care to a patient based on how nurses interact with their environment, and to continuously reconstitute knowledge to adapt practice to meet specific patient contexts (Brandon & All, 2010; Cathcart & Greenspan, 2013; Harlow, Cummings, & Aberasturi, 2007; Piaget, 1952). Clinical wisdom is demonstrated by nurses who are experts in their roles. These nurses have the skill and knowledge to respond to their patients' care needs from experience in their practice rather than relying on rules and maxims. These approaches to practice articulation have challenged the understanding of how nursing narratives can demonstrate and make visible experientially acquired knowledge, skills and ethics that are embedded in every day nursing practice, as well as provide descriptions of how these are developed (Benner, Hooper-Kyriakidis, & Stannard, 2011; Benner, Tanner, & Chesla, 2009). The retelling of nursing narratives around exemplary practice or where a breakdown in practice occurs, resulting in subsequent learning, will be explored in this study. These conversations about the forms of knowledge, relationships, judgement and discernment embedded within the nurses' stories will generate further reflection and a renewed focus on nursing practice (Cathcart & Greenspan, 2013).

Phronesis is described as the development of practical wisdom that guides actions in nursing practice and assumes that practically wise nurses are motivated to pursue safe and good-quality patient care (Sellman, 2009). Phronesis is also described as soft knowledge, and it is distinguished from praxis in that it is wisdom derived from engaging in nursing practice rather than action driven by reflection on theory (Leathard & Cook, 2008). This means that nurses are dealing with the dynamic nature of their everyday work environment, and their development as nurses cannot be reduced to:

> "simple or prescribed responses to the situations" (Sellman, 2009, p. 86),

they face in their everyday work. This reinforces the significant role that self-awareness plays in this wisdom or phronesis for nurses to know when they require further knowledge or skills to practice safely. Further, this supports a main tenet of constructivism whereby nurses are active creators of their own knowledge, and growth is achieved by sharing perspectives and changing internal representations as a response and through ongoing experience and learning (Brandon & All, 2010).

Constructivism operates upon four key assumptions (Brandon & All, 2010), which are considered in the aims of this study to identify, understand and describe the relationship between policy and practice. These assumptions are:

1. Knowledge is formed from existing mental frameworks, with new information changed and added based on previous learning;
2. New information cannot be assimilated, thus creating new areas of thinking;
3. The ability to think critically results in more meaningful learning than memorising information. This is important for encouraging rapid adaptation to changes in practice that are required as evidence changes; and
4. Reflective practices provide meaningful learning to combine new knowledge with existing knowledge.

This constructivist paradigm has limitations in that it places assumptions on nursing or other roles in helping nurses to construct knowledge in their everyday work, and it is largely dependent upon broader systems and socio-professional infrastructure and resourcing. Thus, the research approach is enacted using an explicit framework that integrates post-modernism and constructivism through a lens of ways of knowing in a clinical governance context. These theories are tested using applied techniques relating to policy and nursing practice to understand their strengths, limitations and alignment that is presented to demonstrate their appropriateness and applicability to this area of study (Bradbury-Jones, Irvine, & Sambrook, 2010). In this regard, methodological approaches derived from phenomenology are undertaken to support the methods, data collection and analysis in this research study. Hermeneutic phenomenology is a research approach recommended when seeking to understand the nature and meaning of the lived experiences of a group of participants—in this case, nurses (Heidegger, 1962; Laverty, 2003).

3.5 Phenomenology

The adoption of a constructivist paradigm supports the hermeneutic phenomenological approach that is used in phase one of this study to deal with the interpretive understanding of meaning with a focus on context, and it supports the theoretical perspective by understanding the everyday or lived experiences of the nurse participants (Laverty, 2003). The phenomenology perspective can assist the researcher to generate knowledge about how things are experienced by individuals in their everyday work, in this case, understanding the lived experiences of nurses in relation to hospital policy and their nursing practice (Creswell, 2007; Hesse-Biber & Leavy, 2006). This is established as a research approach for phase one of the study by setting out to challenge or validate the problems identified anecdotally by the researcher in relation to hospital policy and nursing practice. In understanding nurses' every day experiences around hospital policies and nursing practice, the researcher sets out to understand the ways of knowing around sense-making and subsequent decision-making that form action around policy processes and nursing practice. This is key to determining the research methods chosen in phase one, which

include semi-structured in-depth interviews with nurses, reflective documentation processes and reviews of relevant documentation and databases.

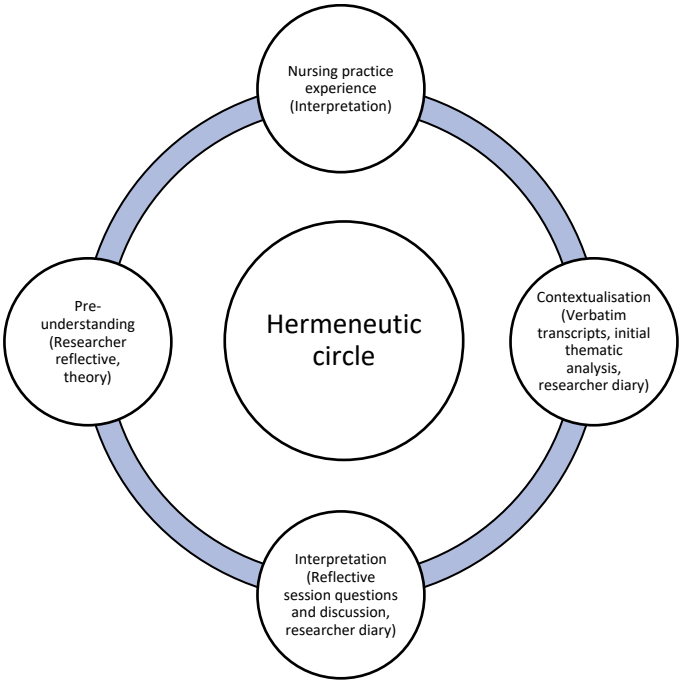
The phenomenological approach provides a richness of data to support an understanding of the perspectives of hospital policy and nursing practice of the nurses participating in the interviews. There is a need to further understand how nurses create meaning and practice in their everyday work, or in the cultural context of a hospital ward setting, in order to achieve the aims and objectives of this study. Hermeneutics offers a valuable opportunity for understanding cultural context. Language as it is written and spoken is an important consideration in revealing the meaning of hospital policy and nursing practice, and it supports an ontology of being in the world that is being studied (Liamputtong, 2010). This means that the interpretation of the phenomenon, hospital policy and nursing practice, needs to be explored in relation to how the language used by participants reveals their being in the world and a reflective cycle to support trust and relationship-building between the researcher and nurse participants to translate knowing into telling (van Manen, 2017). This supports the 'insider–outsider' and reflective approaches whereby the researcher includes their own perspectives in the process of interpretation to demonstrate their own place of being in the world (Rapport, 2005).

A hermeneutic phenomenological approach to the study is considered the most appropriate strategy to assist the researcher to achieve the research aims, particularly from the perspectives and narratives of the nurse participants recruited into the study. Phenomenology is a form of qualitative research that facilitates the researcher to focus on the study of nurse participants' lived experiences (what they experience and how) in their everyday work practice or in their world (Neubauer, Witkop, & Varpio, 2019). Identifying and understanding how nurses perceive and experience hospital policy in their daily nursing practice is key to achieving the aims of this study and discovering the meaning that the phenomenon holds, as the researcher shared the journey of exploring old and new sense-making with the participants. Through an interpretive lens, the ontological and epistemological assumptions are that lived experience is an

interpretive process situated within nurses' every day work. The nurse participants and the researcher are both part of the world being studied, and bias is part of the process; however, the phenomenon is explored and understood by interpretive means (Neubauer, Witkop, & Varpio, 2019). These assumptions are key to the methodological approaches to support the achievement of the study aims, whereby a descriptive understanding of the phenomenon is informed through an interpretive and constructivist lens. A hermeneutic phenomenological approach to phase one of the research strengthens the interpretive understanding of the data, including the involvement of the researcher and their lived experience in understanding the phenomenon.

A hermeneutic circle has been developed by the researcher to reflect the process of applying the methods and analysis within a hermeneutic phenomenological approach, adapted from Sebold, Locks, Hammerschmidt, Fernandez, Trista and Girondi (2017) work on the hermeneutic interpretation of nursing care. This is reflected in Figure 3.1, which explains the process used to understand the data generated, including researcher's reflection and theoretical underpinnings to the study, semi-structured in-depth interview verbatim transcripts, member checking of transcripts by nurse participants, reflective session questions and discussion, and research diary reflections. This process follows a cycle across each nurse participant's interview to assist the researcher with the contextualisation and interpretation of the data generated during the study.

Figure 3.1. Hermeneutic Circle, adapted from Sebold et al. (2017) work on hermeneutic interpretation of nursing care.



3.6 Reflection

Reflection has been defined in many ways. Schon's (1983) seminal work described the importance of reflection in identifying and critiquing the tacit and spontaneous understandings that emerge from repetitive and routine practices. The author argued that practitioners can reflect on how they know in practice in order to make new sense of situations and uncertainties that occur in their practice. Practitioners can also think while they are practicing, which Schon (1983) referred to as reflecting-in-action. In a research setting, the practitioner can reveal to the reflective researcher the way of thinking that has been brought into practice (Schon, 1989). While this provides a sound base understanding of reflection, the process is used in this study as:

> "the conscious engagement on the part of the practitioner to being open to examining their own assumptions and influences on situations, and how the cultures and contexts they are embedded in might be influencing them" (Howatson-Jones, 2013, p. 160).

Reflection is described as:

> "considering and reviewing thinking, actions and circumstances to develop new ideas" (Howatson-Jones, 2013, p. 160).

This implies that we reflect on our thoughts, actions, assumptions and expectations and how they influence our experiences, and that our knowledge and knowing is integrated with self, how we view the world around us and how we act within it (Darawsheh, 2014). In this sense, reflection involves being mindful of situations, behaviours and practice contexts to seek problems and solutions where the role of reflection in learning is a type of internal mentor that helps nurses to integrate personal knowledge into the care situation and recognises related knowledge and awareness of nursing as a community of practice (Iedema, 2011). These are important concepts to consider in the research process for this study, which starts with a researcher reflective that sets the scene for the nurse participants and study setting to provide context and meaning about the study and the researcher. The process of reflection supports the researcher during each part of the research process to provide rationales for decision-making and a discernment process in conducting, analysing and generating relevant findings (Smith, 2006). This understanding of reflective processes underpins the importance of using research methods that help to achieve the study's aims of identifying, understanding and describing the phenomenon of hospital policy and nursing practice.

Reflection is a way in which research is filtered through the interpretive lens of the researcher based on their story and theoretical perspective (Allen, 2003). Recognising that active participation in fieldwork means that the research will affect the reach and effect on the researcher. Reflection makes processes transparent in order to contribute to research rigour and facilitate the reader's assessment of the validity of the findings process (Darawsheh, 2014). Undertaking reflection processes at different points in the research process, such as research design, data collection and analysis, and dissemination of research findings, supports a continuous process throughout the research to maintain awareness of the researcher's and nurse participants' influence on each other and the research process (Darawsheh, 2014). In this respect,

reflection is a critical part of the methodology that is integrated into every aspect of the study, beginning with the planning, and in a structured way by the researcher.

The role of reflection in learning is a type of internal mentor that helps nurses integrate personal knowledge into the care situation and recognises related knowledge and awareness of nursing as a community of practice (Cassidy, 2009). These are important concepts for the researcher to consider as 'insider–outsider' in this study, and for the nurse participants and study setting to provide context and meaning about the study and the researcher. Understanding the theoretical underpinnings of the research provides a basis for reflective thinking throughout the study, whereby the researcher continuously refers back to the research aims, objectives and paradigms supporting the research process.

3.7 Methods

Phase one of the study was undertaken using the primary method of semi-structured in-depth interviews with nurses in frontline, management and executive roles. A parallel understanding of hospital databases, external information and reflective processes provided a context to inform the methods, results and analysis for this study. Explanations of the aspects relating to these research methods are provided below.

3.8 Setting

Three private hospitals (referred to as A, B and C to maintain anonymity) in Queensland were used to conduct a database review of clinical incidents and policies and procedures to provide qualitative context to the study. Hospital A is a 230-bed acute tertiary referral private hospital in a metropolitan location, Hospital B is a 180-bed acute tertiary referral private hospital in a regional location, and hospital C is a 160-bed sub-acute hospital in a metropolitan location. The databases included the RiskMan incident reporting system and an internal document management system. These hospitals were accessible to the researcher as a primary place of employment, and they provided access for the researcher to data and participants as a result of

the ethical review and approval process. Access to these data provided qualitative context to the research in terms of understanding the environment in which nurses as potential participants were working.

One of the hospitals, Hospital B, was chosen as the study site for phase one of the research because of its access for the researcher in terms of locale, the researcher's knowledge of the policy processes and the broad range of potential participants with diverse nursing roles who are supportive of nursing research practice. Nurse participants were identified by the researcher purposively to take part in semi-structured in-depth interviews in phase one. The clinical capability of the hospital includes acute adult and paediatric medical and surgical, maternity services and an emergency department (Health, 2014).

3.9 Participants

The participants in the study were selected in discussion with the hospital executive. They were chosen based on their roles and experience in nursing within one hospital, and included nurses who had more than ten years' experience in nursing and with hospital policies. The sampling method was purposive to identify and select participants whom the researcher identified to be information-rich and who could provide a depth of understanding and the most effective use of limited resources (Palinkas et al., 2015; Patton, 2002). The researcher invited a cross-section of registered nurses working in Hospital B to participate in the study, including frontline nurses, nurse managers and nurse educators that were convenience sampling, with opportunistic sampling of nursing members of the safety and quality team and senior nursing management in executive roles. The researcher aimed to include a minimum of ten nurses who reflected a range of experience and views about hospital policy and nursing practice within one hospital setting.

A participant information kit (PIK; see appendix A) was developed as a three-part document that consisted of a covering letter from the researcher inviting the participant to join

the study, a researcher reflective summary and a consent form to participate in the study, which the participant was required to complete. Participants were given the option to withdraw from the study at any time without repercussion to their working relationships. Further, confidentiality was addressed in the PIK and when meeting face-to-face for the interviews.

3.10 Data Collection

3.10.1 Documentation Review

This study method consisted of analysis of available policy databases and resources to identify the use of systems and relationships between policy and nursing practice. The NSQHS Standards (ACSQHS, 2018) outline policies and procedures that must be implemented and evidenced within hospitals. The researcher identified that an evaluation was required of the policies and procedures that had to be implemented, along with a comparison of those included in hospital document management systems. Further analysis of participants' access to the hospital document management systems, which provide evidence of the reading of policies and procedures, was also identified to be undertaken. This comparison of regulator and accreditation requirements for policy and hospital policies provided context for the scope of policy that nurses are expected to practice within the study setting.

3.10.2 Semi-Structured In-Depth Interviews

Semi-structured in-depth interviews with a continuous process of researcher and participant reflective processes were undertaken throughout the study. The interviews were planned to be conducted over a ten-week period between August and October 2011. Each interview was planned to take 45–60 minutes. Contact with participants was initially made face-to-face and then subsequently by work or personal email (as determined by the participant and with their permission) as their preferred follow-up approach. The aim was to be able to include participants that could assist the researcher in understanding the phenomenon deeply through

adequate exposure to the attributes related to the phenomenon that they had gained through their lived experience (Todres, 2005).

Each interview was arranged at a time and date of the participant's choosing and in a meeting space in either the participant's office or workplace setting, or the researcher's office, for ease of access, privacy and participant familiarity. This approach aimed to provide the participant with the power to control when and where the interview took place, which is an important consideration in building trust and rapport between the researcher and the participant. The researcher emphasised the priority of working with the schedule of the participants, including meeting in suitable venues where the participants would feel comfortable talking to the researcher. The interviews were audio-taped using an audio recorder and a Livescribe smartpen to record audio and the researcher's notes and interview observations onto dot matrix paper, with the data then transferred to secure password-protected computer files electronically. Participants were informed that the interview would be transcribed verbatim to text by the researcher within one week of the interview. The entire text transcript of their interview would then be made available to them, along with initial thematic analysis of key themes identified by the researcher. A three-month period for data collection enabled the researcher to undertake the interviews, complete the verbatim transcripts of the interviews, conduct initial thematic analysis and send the transcripts to the participants so they could provide a review and feedback to the researcher.

Participants were informed that all results from the study would be de-identified by code and that they would have an opportunity to review any material generated to validate the interpretations of their interview data. Each participant was asked to review their interview transcript and to review a summary of the themes that the researcher had interpreted from the analysis of their interview transcript. They were asked to give the researcher feedback regarding whether the interpretation of the themes was consistent with their perspectives, and to clarify any views, point out inaccurate information or provide additional information. Microsoft Word and Excel were the primary software tools used to record and analyse the data.

One broad question and four focus questions were prepared to direct the semi-structured in-depth interviews. Each participant was asked an opening question:

"Can you tell me about your experiences with hospital policy and nursing practice?"

3.10.3 Participant Feedback

Giving a voice to the nurses participating in the semi-structured interviews was central to the research approach, and maximising the validity of the research findings was undertaken through a process of member checking, which is also referred to as participant validation of data and analysis (Birt, Scott, Cavers, Campbell, & Walter, 2016). This form of member checking can be useful in verifying data interpretation to ensure interpretive validity, which can be used to validate themes and categories with participants, as well as interpretations and conclusions. It also encourages the negotiation of meaning, involving the convergence of perspectives, between participants and the researcher. This verification process is an opportunity to check existing data and create opportunities to yield new data (Bradbury-Jones et al., 2010). This is consistent with the hermeneutic circle—the constant movement between interpretation and text or interaction with participants whereby cross-checking the interpretation with participants' original transcripts is critical to maintain closeness to the participants' constructs and interpretation of the data.

One process used for member checking was the verbatim transcripts that were presented to each participant within one week of the interview, when the experience was still fresh in their mind, for review in conjunction with a thematic analysis summary of the prominent themes. This process gave the participants the power to read the transcript and researcher-generated thematic summary and confirm that they said what they meant and that they were comfortable with the information provided and the researcher's interpretation in the thematic summary (Birt, Scott, Cavers, Campbell, & Walter, 2016; Dearnley, 2005). This also provided the participant with an opportunity to withdraw statements or challenge the researcher's interpretation in the thematic summary of information from the interview, or to provide any additional clarifying information

(Birt et al., 2016; Dearnley, 2005). This verification process supported the constructivist epistemological stance of the study, whereby there is a shared discussion of the interview transcript between the researcher and participant that focuses on confirmation or modification of the interview text and can enable the addition of new data. Birt et al. (2016) and Carlson (2010) raised concerns with the process, as participant safety and coercion can make it difficult for participants to disagree with the researcher's interpretation in their presence. However, Harper and Cole (2012) suggested that participants can benefit from seeing their experiences validated and reflected in the data presented, and this may initiate new understandings from participants. Cho and Trent (2006) raised a concern about whether the research process should be transformational for participants in these circumstances. The importance of the researcher's insider–outsider role and the consent process through the PIK attempts to address these potential concerns for participants at the outset and throughout the research process.

3.11 Reflective Processes

3.11.1 Model of Reflection

Many theories and models of reflection in nursing practice can be drawn upon in relation to the research methods used in this study. Reflection has been described as a deliberative thinking process in which nurses look back and examine their past self and their practice to improve future practice (Clarke & Graham, 1996; O'Donovan, 2007). A model of reflection used as a basis for researcher and participant reflection in this study is an approach that provides cues to assist nurses in reflective processes to make sense of and learn from their experiences (Johns, 1994). Johns' model focused on four areas: description, reflection, influencing factors and learning. This was viewed as a practical way to work with each nurse participant to reflect on the observational fieldwork brought forward by the researcher and to provide a framework for the participant to discuss, make sense of and learn from their experiences. The researcher was

interested in privileging the nurses' voice and perspective in this process as a primary way of understanding the relationship between policy and nursing practice.

A model of reflective practice was included in this study during the reflective session with participants when reviewing the interview transcripts and discussing the data. It included four phases (Johns, 1994):

1. Description: A description of the experience and identification of the key issues to pay attention to;
2. Reflection: What was trying to be achieved, why the nurse acted the way they did, the consequences of those actions for the patient and the nurse and others, and how the nurse and patient felt about the experience;
3. Influencing factors: The internal and external factors and sources of knowledge that affect the decision-making and actions of the nurse, whether any alternative strategies were considered, other choices that may have been available and the consequences of those other choices; and
4. Learning: How the nurse made sense of their experience compared with their past experience and future practice, how the nurse currently feels and how the experience changed the nurse's way of knowing in practice.

This reflective process provided a structure or framework to support the review of the observational fieldnotes and was a focal process for discussing the vignettes identified in the description phase of the process. A reflective process checklist was developed and maintained throughout the research process in phase one to assist with the reflectivity and thematic analysis processes throughout the entire research process. An approach to achieving researcher reflective processes and transparency between the researcher and participants was described by sharing the data and transcripts with the participants and as a way of exposing the voice and subjectivity of the researcher in the construction of knowledge and participation in the research process

(Carroll, 2009). This also provided an opportunity to reflect on power relations in the fieldwork, which were emphasised to be at the forefront of the researcher's practice and explicit within reflexive processes (Carroll, 2009).

3.11.2 Researcher reflection

The researcher reflection was included in the PIK along with the consent form and the participant information form. It was important to disclose to participants that the researcher worked in a senior role within the regional organisation, as well as what was motivating the research in this area to be undertaken. The researcher disclosed being a registered nurse employed full-time as the Regional Safety and Quality Manager within a health and aged care provider operating in Queensland. The researcher's role as a nurse and senior manager with a large Australian healthcare provider meant that they were in a fortunate position to talk to nurses and managers at the ward level to try to understand the relationship between hospital policy and nursing practice. The researcher was positioned to take this knowledge back to line management to inform other senior managers and leaders of the day-to-day reality of hospital policy and clinical practice.

The following researcher reflection was provided to each participant in the PIK:

> "As a researcher, it is important for me to disclose to all participants that I work in a senior role within the organisation. I am a Registered Nurse employed full-time as the Regional Safety and Quality Manager (2005–2013) and National Director of Clinical Governance (2014–2016) within the organisation, a health and aged care provider operating in Queensland under the governance of a national organisation. The research project will involve the three private hospitals operating in Queensland.
>
> I recognise that my role in the organisation may cause some concern among potential participants about what information they feel comfortable to openly provide, and how

this information may be used that may affect them. It is important for me to raise this potential issue upfront and reassure all potential participants of my commitment to undertaking ethical research and adhere to a code of conduct, and to present my views and what I will do with any information provided to me. Firstly, the main reason for me undertaking this research is because of my own lived experience as a Registered Nurse, a Ward and Executive Manager, and a Safety and Quality Manager/Director of Clinical Governance over the past 30 years. I have observed how many hospital policies exist, with varying forms of access to them, varying levels of evidence basis, written by managers with varying levels of experience and understanding of their application, with limited implementation and evaluation processes, and where they can become the focus of regulators and judiciary when an adverse event is being reviewed or investigated. So many questions arise in my mind and from my experience: Is there a policy in place? If so, what does it say the nurse should have done? Did the nurse know about the policy? If not, why not? If so, then how did they come to know about it? Did the nurse follow the policy as it was written? If not, why not? If so, then why? Does the policy reflect the reality of the complexity and context of local clinical practice? What was the implementation process for the policy? Has the policy been regularly evaluated? If so, how has it been evaluated and has anything changed in the policy or practice as a result? There are so many hospital policies for nurses to know about that are applicable to their everyday practice. I wonder how anyone can ever really know about what is included in every hospital policy that relates to their practice, and how does a casual or agency nurse know and understand what the local policies are and how to access them?

While various external bodies have an expectation or requirement that a number of hospital policies are implemented and evaluated to ensure patient safety and high-quality care, my personal view and lived experience is that those expectations may be unrealistic

and reflect a disconnect between the external complexities, context and technology and daily workloads of nurses at the frontline.

My role as a senior manager in the organisation means that I am in an extremely fortunate position to talk to nurses and managers at the frontline, the ward level, and to try to understand what is actually going on, and then to take this knowledge back up the line management tree to inform other senior managers of the day-to-day reality of clinical practice and assist in planning strategies that can more appropriately improve the relationship between the policies that we are required to implement and evaluate, and what we really actually do that makes a real difference to nurses and patients for safer and higher-quality care.

All information that I receive from participants will not contain any individually identifiable references to names, titles, organisations or locations. I have presented a summary of the research proposal to the General Managers and Directors of Clinical Services in the three targeted hospitals for participation, and they have provided their support for the conduct of this research study. I have provided a research application to the Human Research Ethics Committee of the organisations and been given written approval to commence the study on the basis of their ethics approval".

3.11.3 Reflective Diary

The researcher maintained a reflective diary pre- and post-interview for each participant. The purpose of this diary was primarily to record thoughts, ideas and perspectives prior to the interview with the participants. This record aimed to assist in identifying assumptions or biases of the researcher that could affect the interview, and to provide a post-interview personal debrief of the interaction while the thoughts and feelings were fresh. In a phenomenological sense, the pre-interview reflective diary process provides a form of bracketing (in this thesis, 'bracketing' refers to a method that assists in recording the researcher's preconceptions that may affect the

interpretive processes during the interview or in post-interview processes) where the researcher's preconceptions were recorded in the reflective diary. This enabled the experiences and information from the interview to be made sense of and critically analysed before they could be consciously or subconsciously synthesised by previous knowledge and experiences (Beech, 1999). In a phenomenological context, this aimed to hold, as much as possible, a natural attitude to the research activity (Paley, 1997). In this sense, the reflective diary was maintained throughout the study to support the analysis and self-awareness of the researcher's contribution to and effect on the study from the planning, implementation, analysis and write-up stages.

A reflective framework for the diary entries was adopted (Johns, 1994; Schon, 1987). This included a pre-interview reflection that enabled the researcher to spend dedicated time preparing for the interview, and to consider issues and beliefs that might require bracketing that could otherwise interfere with the clarity of information and experience of the interview within the consciousness (Wall, Gunn, Mitchelton, & Poole, 2004). This included reflections on situations that the researcher was aware of in relation to the nurse participants and current issues relating to policy and nursing practice within the hospital that may influence the interviews. It was important to consider and plan for what the researcher would do to address any information that arose during the interviews that could pose safety risks to patients, as the 'insider' part of the researcher's role in the organisation involved an explicit responsibility to ensure patient safety. This may mean that issues may only be able to be partially bracketed, and it was important to reflect on the developmental process of bracketing as the experiences progressed.

Reflective writing was undertaken with 24 hours of completing the interview to enable the researcher to further reflect on and analyse the extent to which the bracketing was achieved where appropriate. An important phase of the reflective framework was to identify any new learning that had taken place as a result of the interview and its reflection. The final phase of the reflective framework was to identify how any new learning could be used, including lessons learned during the interview that could provide insights into bracketing and processes for future

interviews—for example, what worked and what had to be revised in the methodological process as the research progressed (Wall et al., 2004).

3.12 Data Files

Four file types were maintained to assist with the data analysis in phase one, as outlined below:

1. A transcription file was maintained of the taped interviews, which were converted verbatim to a text-based format and sent to the participants for feedback;
2. A memo file was maintained of the data recorded during the data collection phase and for the data analysis. This included the write-up phase of the study, including a summary of participant and environment demographic attributes to assist in sense-making;
3. An analytic file was maintained of a detailed critical examination of ideas that emerged in relation to questions as the research progressed, as well as reflections and insights that influenced the ongoing direction of the research; and
4. A coding file was maintained that included transcript summaries, coding and themes identified, along with participants' feedback.

The transcription file facilitated the maintenance of a summary prepared in text format to give to each participant to seek clarification on how the descriptive results compared the thematic interpretations with their experience and whether any aspects of their experience had been omitted.

3.13 Thematic Analysis

An iterative process for qualitative research data analysis was worked up from the data (Richards, 2009; Tracy, 2013b) following the hermeneutic circle process outlined in Figure 3.1. Through the process of writing fieldnotes and memos against a background of reflexivity and reflective processes, Richards (2009) and Tracy (2013b) described how data records with thick

descriptions that were accurate and contextual were an important starting point for the data analysis because one does not know in advance what will be learned from the data. This complexity and context were important in creating a path for ideas to emerge from the data. The iteration was a reflexive process that helped the researcher to visit and revisit the data and make connections to emerging insights that refined the focus (Tracy, 2013b).

The process of reading and re-reading typed transcripts of the participants' interviews and listening and re-listening to audio files of the interviews facilitated rich opportunities for reflective writing and focusing on interesting passages to compare their relationship with other situations and players (Richards, 2009). In this sense, recording fieldnotes on ideas that emerged around the conditions, consequences, strategies and interactions of the idea or attitude facilitated a greater understanding of the idea and was further enhanced by linking data between themes and ideas.

Chronological ordering was undertaken of the interviews, fieldnotes, document review, reflexive and reflective diary notes, and participants' feedback in order to organise all research data and provide evidence of how the data were collected and interpreted over the duration of the study. The interpretation of salient issues was influenced by the organisation of the data (Tracy, 2013b). Reflective activities were undertaken during the data collection and analysis phases of the study before and after each interview, after typing and re-reading each interview transcript, and after further re-reading each transcript. The transcripts, thematic analysis and participants' feedback were reviewed multiple times by the researcher to answer introspective questions about the methodological alignment to the research processes undertaken. The aim was to identify any new information and engage in learning to improve the researcher's performance in the interview process and analysis.

Within the coding file, codes were created as words or short phrases that captured the salient attributes and language identified in the transcripts. Following receipt of the participants'

feedback, the researcher planned a process of secondary cycle coding whereby the codes identified in the primary coding were synthesised and categorised into interpretive concepts. These secondary codes reflected a method of explaining and identifying patterns and relationships in the data based on the context and attributes of the methodological approaches previously described. The movement from emergent and descriptive primary coding to more focused and analytic secondary coding supported understanding that targeted the research questions, aims and objectives (Tracy, 2013b).

The analytic files provided an opportunity to continuously test pre-research assumptions by comparing and contrasting assumptions with findings in the research text. This enabled the researcher to address any prejudices that had developed from the literature or personal experience. This approach supported the application of the hermeneutic circle in the qualitative research process and provided an opportunity to explore emerging themes once there was a sense of data saturation, that is, when no new themes emerged from the interviews. The analytic file included memos, diary notes and mind maps, which assisted in understanding stories within the data and provided an intermediary step between coding and recording the analysis material in the thesis. This helped the researcher to move from comparing the data to understanding and explaining the observed phenomenon (Tracy, 2013b). The data were considered from both positive and negative case analysis perspectives in order to challenge emerging explanations in phase one of the research, as the emerging themes highlighted different views of the participants working as nurses in various roles in the hospital. Looking for exemplars where data saturation was evident was an important method used to understand the emerging themes.

The main goal of fieldwork is to generate data from or directly related to activities that occur in the study setting (Emmerson et al., 1995). Theory is inherent in the notion of data; thus, theory and data cannot be distinguished as two separate and distinct entities. Therefore, reflection on related theoretical concepts was an ongoing process during the data analysis. This consideration of theoretical concepts emphasises that data always have multiple meanings and

are always a product of prior interpretive and conceptual decisions (Emmerson et al., 1995). Nowell, Norris, White and Moules (2017) emphasised that researchers need to be transparent about the data analysis process and how their analysis is informed to enable readers to evaluate the trustworthiness of the research process. Holloway and Todres (2003) supported this argument that making explicit the epistemological position of the research assists in underpinning the study's empirical claims in a coherent manner. Flashes of insights occurred through this process of writing memos and applying reflective practice to this process. The researcher's prior critical analysis of literature and events, theoretical concerns and connections with other similar events were built into the process of taking fieldnotes. Further, the process of analysing the memos and transcripts facilitated the selection of particular incidents or events to give them priority and generate a greater understanding of them in relation to others (Emmerson et al., 1995). This approach was used in the thematic analysis, where the primary analysis generated thematic areas that are described in the findings section of this study. Further analysis of these themes led to a process of focusing on areas to identify thematic relationships and linkages that challenged how the themes operated in the contested terrain of hospital settings and with healthcare professionals and managers. The negotiated meanings from these fieldnotes were generated from the nurse participants and the researcher and emphasised the important role of reflection in developing a shared understanding of making sense of hospital policies.

3.14 Data Storage and Security

The process for data security and storage was explained to the participants. During and after the study, the data were stored in paper format in a locked cupboard in the executive office and in soft copy format in secured network folders that were accessible to the researcher only. All files were password-protected within the secure network folders and access was limited to the researcher only. The organisation has a Regional Retention and Disposal Policy that requires all research records to be securely stored for a period of seven years before undergoing secure destruction through the shredding of hard copies and erasure of soft copies as per the Information

Technology and Communication Department Policy. At the time of the study, this was the only organisational policy that addressed document retention.

3.15 Ethical Considerations

Ethical considerations for this research study encompassed the formal process of ethical review and approval and the ongoing professional ethical considerations that arose as an 'insider' and 'outsider' throughout the research process when patient safety observations and information were made accessible to the researcher. The formal processes of ethical review and approval involved the completion of a National Ethics Application Form (NEAF) for this study and adherence to the National Health and Medical Research Council's (NHMRC) ethical conduct in human research (NHMRC, 2007, updated 2018). A PIK was developed that included a covering letter to the participant, participant information, researcher reflective explaining who the researcher is and why the research is being conducted, and a participant consent form (see Appendix A). The NEAF, PIK and a letter was submitted for expedited review to the chairperson of the hospital's Human Research Ethics Committee (HREC) requesting consideration of the study as a low-risk phenomenological study, and written approval was received in August 2011 (see Appendix B for ethical approval for phase one of the study).

The participants' information was collected without any identifying information for the individuals so their experiences would not be directly attributed to any individual in terms of commentary or detail for adverse events or incidents. It was important to understand the perspectives of a range of different stakeholders at different levels in the system in order to identify patterns and themes in the relationship between hospital policy and nursing practice. The aim was to improve patients' safety and care experiences by gaining a better understanding of frontline complexity, decision-making and taking action that involves many different nurse participants. The reflective processes undertaken by the researcher and nurse participants facilitated a discussion of the ethical issues arising within the research process.

All potential participants were given a copy of the researcher's reflective and the participant information sheet and consent form prior to consenting to participate in the study. The PIK specified that participation in the research study was voluntary, that participants could withdraw at any time without explanation, and that their decision to withdraw would not affect any existing relationship with the hospital or university. The participant information sheets detailed how the participants' confidentiality would be managed in relation to data, computer files, documents arising from the project and the management of non-identifiable data. Contact information for the hospital was provided through the HREC chairperson in case participants had any complaints or concerns about the ethical conduct of the research. The researcher's role as an employee in the Regional Safety and Quality team was explained both in the PIK and in the face-to-face interviews. The researcher emphasised that their role did not involve any line reporting to any staff within the hospital that were involved in the research study. Following the interviews with the participants, a summary of the non-identifiable data was provided to the participants to seek feedback on the accuracy of the transcript and the themed information.

3.16 Conclusion

Phase one of the research study used a post-modern and constructivist paradigm with a hermeneutic phenomenological approach. Semi-structured in-depth interviews were conducted with ten nurses in one acute private hospital to understand the phenomenon of hospital policy and its relationship with nursing practice. During this phase, the researcher used reflective processes with the participants, with an 'insider–outsider' reflexive approach dominating the research processes. This provided benefits in terms of access to information, data and participants, but it also created challenges in terms of power and transparency of roles, thereby emphasising the importance of ensuring rigour in the choice and application of the research methodology and methods for this research. The next chapter describes the findings and analysis of phase on

Chapter Four: Findings and Analysis—Phase One

4.1 Introduction

Previous chapters outlined the approach used to explore nurses' every day experiences with hospital policy and to understand reflections on the relationship between policy and nursing practice through the experiences of the researcher and the participants. This included some exploratory work to identify what the problem with policy is or might be, and whether it is just a problem that the researcher had experienced or whether it was a more generalised experience with policy and nursing practice that other nurses struggled to make sense of. Having previously outlined the problem, aims and objectives, relevant literature, methodology and methods, this chapter presents the findings and analysis of phase one of the research study.

Differing epistemological positions and data collection methods that incorporate qualitative contextual approaches should be used to obtain a richer understanding of the relationship between policy and nursing practice. Further, to undertake a research approach logically that would be relevant and appropriate, a bi-phase approach to the research was undertaken. Phase one aimed to explore and gain a greater understanding of the everyday experiences of nurses and how they make sense of the relationship between policy and nursing practice.

4.2 Findings

4.2.1 Qualitative Context

The researcher accessed three hospital policy databases to obtain data on who accessed policies and procedures on a daily basis. This included a comparison of policy and procedure requirements by regulators and accreditors, a summary of NSQHSS policy requirements, a review of the use of a document management system to access policy and procedures in a

hospital setting, an understanding of the adverse event and policy context, and an understanding of the clinical incidents and policy context. To determine a frame for open-ended questions, existing hospital databases and relevant external reporting and documentation were analysed to provide a qualitative context for the study, as discussed in Chapter Two. The reflective practices of the participants and researcher were acknowledged as a continuing narrative in the context of understanding the perceived relationship between, and strengths and limitations of, policy and nursing practice. This analysis established the background context to analysing policy and nursing practice to understand the aims of the study.

4.3 Semi-Structured In-Depth Participant Interviews

The study methods for phase one consisted of semi-structured in-depth interviews and a continuous process of researcher and participant reflective practice throughout the study. The nurses who were selected as participants performed a range of nursing roles within one hospital. These roles included frontline nurses with more than ten years' clinical experience, Nurse Unit Manager (NUM refers to the senior nurse in charge of a ward), Hospital Coordinator (HC refers to the senior after-hours nurse responsible for coordinating the hospital after office hours), Nurse Educator (NE refers to the senior nurse responsible for nursing education hospital-wide or in designated clinical units), Quality and Risk (QR refers to the team of Quality Risk Manager or Quality Associates, who are senior nurses responsible for coordinating safety and quality across the hospital), Director of Clinical Services (DOCS refers to the senior nurse in charge of the hospital) and nursing General Manager (GM refers to the senior executive responsible for all operations of the hospital). The researcher considered these roles and participants important because they had experience with policy and practice over a lengthy period, as well as knowledge of policy systems and processes within the hospital setting.

There were 12 potential participants approached by the researcher in person to be part of the study, and they were given a PIK (see appendix A). These potential participants were

identified by the researcher as nurses with experience from frontline nursing to senior nursing functions and hospital executive roles, thus forming a purposive sample of potential participants to provide an in-depth understanding of the phenomenon under study, as outlined in Chapter Three. Written consent was obtained from the first ten participants recruited by the researcher. The study was fully explained to them, and the option to withdraw was presented.

Table 4.1 summarises the participants' demographics to assist in interpreting the data generated from the interviews with each participant.

Table 4.1 Descriptive summary of participants' demographics

Participant Code	Participant Gender	Participant Role	Participant Years of Experience in Nursing	Participant Age Range	Participant Recency of Clinical Practice (Frontline Nursing Practice Within Past 12 Months)
P01	Female	Nurse Unit Manager (NUM)	20+ years	40–50 years	Yes
P02	Female	Registered Nurse (RN)	10+ years	30–40 years	Yes
P03	Female	Quality Coordinator (QC), QS team	20+ years	40–50 years	No
P04	Female	Registered Nurse (RN), QS team	20+ years	40–50 years	Yes
P05	Female	Quality & Risk Manager (QRM), QS team	20+ years	40–50 years	No
P06	Female	Registered Nurse/Midwife (RN/RM)	20+ years	40–50 years	Yes
P07	Female	Hospital Coordinator (HC)	20+ years	40–50 years	Yes
P08	Male	General Manager (GM), nursing executive	20+ years	40–50 years	No
P09	Male	Nurse Educator (NE)	30+ years	50–60 years	No
P10	Male	Director of Clinical Services (DOCS), nursing executive	20+ years	40–50 years	No

The interviews with the participants occurred over a three-month period in the hospital setting. The researcher had met nine of the ten participants previously, and already knew six of the ten participants through regular professional interactions. This was a benefit at the start of the interview, as there was already a degree of professional familiarity, trust and respect between most of the participants and the researcher. The interviews were conducted in office areas that provided privacy, either in the participants' usual work area or the researcher's office within the hospital but outside the participants' usual work area. There appeared to be a genuine openness

and frankness in the verbal and non-verbal language expressed by all participants, as reflected in the interview transcripts and reflective discussions. The participants' response towards the researcher and the research process supported the insider aspect of the study's approach. The transcripts showed the honesty and transparency with which each participant spoke, and they provided detailed and often highly emotive narratives to explain the participants' sense of frustration or perspectives of their personal experiences with hospital policy.

4.4 Thematic Analysis

After the first and second interviews, there were emerging themes and subthemes that provided an opportunity to seek clarification of the participants' experiences in order to support the comparison and contrasting of perspectives on common thematic areas. Undertaking reflective activities throughout the interview processes was critical in opening up the data to better understand different issues and perspectives. Throughout the study, the research process reinforced the view that the researcher and the research could not be meaningfully separated; thus, the effect of the researcher was identified and acknowledged throughout the research process (Koch & Harrington, 1998; Laverty, 2003; Lofland et al., 2006). The reflective activities provided this opportunity, including pre- and post-interview researcher reflective memos, researcher diary notations and reflective discussions with participants post-interview and following their review of the transcripts and initial thematic interpretation. There were times during the interviews when, in the role of registered nurse and manager, the researcher felt challenged to intervene in a scenario, and undertaking reflective writing assisted in clarifying the issues and providing transparency of roles for the researcher as researcher and manager. Participants' anonymity was maintained.

A process of thematic analysis was undertaken to understand the data and identify areas that required a greater understanding of the relationship between policy and nursing practice (Richards, 2009; Tracy, 2013b). A number of overlapping themes were identified in the initial

process of coding and thematic analysis from the participants' interviews and the researcher's fieldnotes. The areas that nurses discussed were grouped into six thematic areas with subthemes. The six thematic areas were:

- meaning;
- practicality;
- local workforce culture processes;
- variation or non-adherence;
- nursing practice gap; and
- clinical governance.

The first theme of policy meaning provides the definition for policy used in the following five themes. The remaining five themes were considered through the analytic process as having both positive and negative attributes at times, as different participants viewed the same or similar aspects of policy in a positive light or alternatively a cynical and more negative light. It became apparent during the process that participants viewed the same theme or subtheme in a binary fashion—that is, as positive or negative—and at times presenting contradictory perspectives. These perspectives will be outlined in the findings of each theme. Each theme is explained in terms of the findings and analysis below.

The thematic analysis approach was used to analyse the themes within a hermeneutic phenomenological framework, where reflective cycles throughout each phase supported an inductive approach to exploring and supporting the themes to be identified. This application of thematic analysis assisted in describing the meaning of nurses' lived experiences in relation to hospital policy and nursing practice. A theme was defined as an important concept or attribute that was identified by the researcher in the data and that represented a pattern of meaning that captured something relational to the research aims (Braun & Clark, 2006). An inductive analytic approach supports the description and exploration of themes that are strongly linked to the data

but that may initially bear little direct relationship to the research questions, and this provided a coding approach to the data without fitting the data into a pre-existing framework (Braun & Clark, 2006). This hermeneutic approach to understanding the themes enabled the data analysis to progress from descriptions to interpretation and understanding the broader meaning of the data.

A six-phase approach was used to support and guide the analysis of the research findings and the model of thematic analysis (Braun & Clark, 2006). Reflective processes were to be integrated throughout each phase as familiarisation with the data, generalisation of codes, searching for themes, further review of themes and subthemes, definitions and refinement of themes, review of the data review, and finalisation in preparation to write up the findings. The phases undertaken for thematic analysis are described in further detail below:

- In phase one, the researcher initially became familiar with the data. Given that the researcher collected all of the data, they were able to develop some initial perspectives and become familiar with the data through the research processes. The attention required for verbatim transcription contributed to a closer reading of the text by the researcher, and the transcripts were cross-checked against the original audio recordings of the interviews before progressing to phase two and sending them to participants for reflective review;
- In phase two of the thematic analysis, initial codes were generated. These codes were identified as key features of the data following their organisation into meaningful groups. This was achieved by transferring the entire dataset into Microsoft Excel and applying colour-coding to consistent wording and concepts. Detailed data extracts for each code area were identified and collated. A mind-mapping process was developed to facilitate the overall conceptualisation of the data patterns and relationships between them in preparation for progressing to phase three. A copy of the verbatim transcript and initial

thematic coding was provided to each participant as soon as possible after completing the interview to seek participants' feedback and reflective insights;

- Phase three of the thematic analysis involved searching for themes. The codes that had already been identified were refocused to analyse the high-level themes. The codes were then sorted into themes by participant in an Excel matrix format. Further patterns of negative or positive attributes of similar data from different participants were identified in this process and reflected as colour-coding in the matrix—green for positive attribution of the data and red for negative attribution of the data. These themes and subthemes were then mind-mapped again to further refine the conceptualisation of the data patterns and relationships before progressing to phase four;
- Phase four of the thematic analysis involved a further review of the themes and subthemes identified in the previous phases, including consideration of the participants' feedback. The researcher found that some themes that had been identified earlier were re-assessed not to be themes upon review and refinement. This ultimately reduced the themes to five key areas. This review process then supported the transition to phase five;
- Phase five supported the definition and further refinement of the identified themes to provide clarity on what the theme was about and what aspect of data the themes captured. Detailed analysis was written for each theme to uncover the stories they told and how they fit into the broader research question. The researcher was able to step away from the thematic analysis upon completion of the interview processes and then return to the analysis with a renewed perspective in phase six; and
- Phase six provided an opportunity to review the data to support an analytical approach that considered each theme individually and in relation to the other themes. The transition to phase six contributed to the final analysis and write up of the research in the findings that follow. Data extracts were collated in association with the theme generation and

refinement and are provided in the findings to demonstrate the prevalence of the themes within an analytic narrative.

The thematic analysis process identified six key themes, which are presented below with illustrative quotes from the participants, followed by analysis.

4.4.1 Policy Meaning

Illustrative quotes of policy meaning are presented below to explain nurse participants' lived experience and their meaning of the relationship between hospital policy and nursing practice. Analysis of the quotes is provided at the end of each set of quotations. A frontline nurse described policy as:

> "a general overview of what this matter will be. And procedures are rules or guidelines to follow. Well, I guess a policy can still be guidelines, but a procedure is how to do it step by step and a policy is, to me, an overview of this is what we do". (Participant two)

Other participants in the management nursing group made similar comments:

> "I see policies as a guide to practice. When you come to a new place you are not sure how this place does that, but you get a good policy and you go, yeah, that's how they do it here, but you shouldn't be beholden to it". (Participant one, NUM)

> "Well they are pivotal in guiding what nursing staff do, especially with the junior nurse". (Participant three, QS)

A frontline nurse commented:

> "I do not think most people know the difference between policies and procedures. There are multiple things, there are standing orders for specific doctors, then on top of that you've got your guidelines, so there are so many things, so you can understand why

> people actually get a little bit confused and its maybe just easier to ask somebody what we do here". (Participant two)

Another frontline nurse commented:

> "So, while they all know it's a procedure, they call it a policy because they tell me it's just easier, it sounds better, it would be silly to call it a procedure about a procedure" (participant eight, nursing executive), and "the terms policy and procedure, they mingle in my mind". (Participant six)

Participant three, QS, stated:

> "Procedures are a procedural list of what to do, but we still refer to them as policies, because, procedures, I think the word itself gets mixed up with doing a procedure, so if you're saying you've got a procedure to cover a procedure, it's easier to say I've got a policy to cover a procedure".

An experienced frontline nurse acting in the NE role described confusion about when to add detail to a policy or procedure and when to leave it out:

> "I wrote the continuous renal replacement policy for dialysis, and I did all of those steps and then they told me to take all of that out because it should just be an overarching policy about nursing considerations and whatever. But then you know, I was told last week I needed to write this tracheostomy one with everything that went in there".

Participant seven, an experienced frontline nurse, also commented on the extensive detail written into policies and began reflecting on critical thinking in nursing and how it relates to policy processes:

> "They are written to be dummy proof for the nurse that should know but doesn't".

This theme relates to the meaning that participants placed on hospital policy and is defined as the language and mental model used by nurses to think about and describe their nursing practice relating to the use or consideration of documents or concepts such as policy, procedures, protocols, guidelines, rules and work instructions (Senge, 1990; Evans, Palmer, Brown, Marani, Russell et al., 2019). The interviews provided an opportunity to explore the meaning of policy for each participant based on their everyday experience and the context of their working environment and roles. An interesting theme emerged early in the interviews, with the participants relating the concept of policy meaning. The researcher explored this concept with each participant. This was important because it provided a foundation for understanding the context and meaning for the other emerging themes.

The participants provided a range of perspectives of the meaning of policy and procedure, which revealed inconsistency in their recounting of the concept of policy as a guide to practice, as well as confusion in the use of terminology. Some participants explained that most nurses do not know the difference between policies and procedures, and they use the terminology interchangeably. Other participants concurred that there is some confusion in terminology. Policy is the generally accepted term used by all participants in their everyday work, even if they are referring to procedures in some cases and policy in others, or other documents such as protocols, guidelines and work instructions. The remainder of the themes discussed in the thesis will continue to use the term ‘policy’ as a notion that may refer to policy and/or procedures as conceptualised by the participants in their everyday experiences practicing as nurses.

4.4.2 Policy Practicality and Local Workplace Culture

Illustrative quotes of policy practicality and workplace culture are presented below to explain the nurse participants’ lived experience and meaning of their relationship between hospital policy and nursing practice. Analysis of the quotes is provided at the end of each set of

quotations. Attempting to understand what had changed in a policy or why it had changed was described as challenging by participant one, NUM, who related:

> "There's thousands [laughs] you know. When I get policies, there are ten policies here [points to a pile of papers on desk]. Well, you know there's a change if they tell you, but you only really know what the change is if you have the old one to compare it to, and who has the time to sit there and do that? So, the only people that really know what the changes to a policy are and why there needs to be a change. Most people don't mind change if they can see it's beneficial for patient care".

Participant two, a frontline nurse, explained:

> "I do really think it is a cultural thing as well. Because the people down there have been there a long time, and this is how we do things here, and this is how it's going to be done. Having the influential people on side is definitely a big thing. Even where I've come from, you know, there's the influential people who say, 'this is how it's going to be done'. So, the NUM and then you've got people under them, so the level two's, if she says you're going to do it, and the level two's do it, then everybody else is going to follow. If there is something else that needs to be implemented, and the NUM and the level twos aren't going to be interested in doing it, it's not going to happen".

Other participants reinforced participant two's perspective about the uptake of policy, stating:

> "It's culture. I think also once there has been a change with something that has been implemented with a type of culture, this is the way we do things". (Participant four)

> "If someone in one of those leadership roles says that this is a load of nonsense, those under them usually say it's a load of nonsense as well and it doesn't get done, whereas if they say this is a great idea, then everyone does it". (Participant seven, HC)

Participant nine, NE, described the particular effect of culture on the implementation of the surgical safety checklist, commenting:

> "Policy is more nursing-led or directed, team time-out involves people other than nurses, surgeons and anaesthetists, and we haven't been able to change that culture, you know, we've done lots of education so they all know, you know the incidents that have occurred with wrong-site surgery—what's happened to those patients. It's not all; it's only a couple of areas in Theatre. The nurses are happy to abdicate their responsibilities really, and say 'well, it's up to the Doctor', and if the Doctor doesn't want to do it …". (Holds hands up, palms facing upwards, and shrugs shoulders)

This policy practicality and local workplace culture theme relates to the meaning that participants expressed with a consistent curiosity of asking why, what and how policies need to be changed or implemented (i.e., their practicality in every day practice) and the role of the NUM and level two nurses (in this thesis, level two nurses refer to ward-based nursing team leaders to called clinical nurses or level two nurses) as leaders in driving the culture of policy uptake. These components of the theme were revealed through the interviews and thematic analysis process. Asking 'why' was a frequent question identified by the frontline nursing participants when reflecting on their experience with hospital policies. There were examples from participants who believed that the NUM or level two nurses determined the local workplace culture, did not value the role of policy in supporting nursing practice, were unapproachable to ask questions, or openly supported nurses' undertaking workarounds to address patients' needs.

Understanding the significance of local workplace culture and change processes was reflected as a gap in knowledge identified in the literature review. The effect of the perceived practicality of policy by frontline nurses, and clinical nurse managers in particular, also affected the culture created by nurse leaders in local workplace settings. According to the participants, this had a significant effect on policy uptake by nurses in their everyday work. The local

workplace culture extended beyond nursing leadership into medical leadership in the operating theatre using surgical safety checklists, highlighting the ongoing policy–practice gap.

Policy practicality aimed to describe the issues raised by participants in relation to how policies can be used in a practical sense in the clinical setting. Most participants explained that the policies that work well or are well used are those related to nursing practices that are not performed very often, or those in which there is a high risk of them being performed incorrectly. Participants related experiences of locating the policy with the piece of equipment or attached to the medication chart, which was most effective because it was there when they needed it.

Most participants discussed how local workarounds have emerged to support practical approaches to carry out clinical practices in lieu of accessing the relevant policies, such as using card files, cheat sheets and quick reference folders. Three participants from QS viewed this unfavourably because it may expose the patient, nurses and organisation as regularly deviating from the policy or not referring to the policy at all. However, frontline nurse participants made reference to the lack of relevance of or access to the associated policies and the local view that the workarounds are safer and well used, whereas the policies are not well used. One participant in QS viewed noted that workarounds will not change until staff see a direct negative effect or patient harm as a result of them, such as in the Schedule eight medication event in a peri-operative area or as a recommendation in an RCA or investigation. Most participants discussed how the use of a serious incident or adverse event is an effective driver for using policies, as staff can see the cause-and-effect relationship between nursing practice and patient harm, which leads to policy uptake.

4.4.3 Policy Processes

Policy processes is a large theme that covers a broad range of aspects for the practical application of policy, with a number of subthemes outlined for completeness of explanation. Illustrative quotes of policy processes are presented below to explain the nurse participants' lived

experience and meaning of their relationship between hospital policy and nursing practice. Analysis of the quotes is provided at the end of each set of quotations. Participant one, NUM, asked:

> "How can all nurses possibly know every policy that the hospital has, and still get their job done without constant interruptions to look up the intranet to check them?"

Participant ten, a nursing executive, explained:

> "You look at policies now, they're in fact very prescriptive things, and they're so detailed you know, so clean your trolley, and do this, and explain to the patient, pull the curtain, wash your hands and go back, and all this sort of stuff. [short pause] We're actually spoon-feeding people that we think should be actually more academically trained, in that they've gone to university and not trained in hospitals like what we did in the old days, you know, see one do one. We shouldn't be spoon-feeding in an evidence-based world; we should be trying to coach them and otherwise you're not going to precept and you're not going to mentor these kids. You're just going to do the old monkey see, monkey do".

One participant from the QS team argued strongly that policies should be detailed enough for a general RN to follow their scope of practice and competence. This was used as the rationale for providing a large amount of detail in the policy to enable general nurses to perform some tasks in specialty areas. However, participant four, a frontline nurse acting as an NE, argued the opposite view:

> "Nurses should not be performing tasks in any policy that they are not deemed competent for, and hence if deemed competent through formal competence assessment, then the policy should not need to be detailed and prescriptive".

The subthemes provide a further explanation of the lived experience of nurses with policy processes. These include policy governance, access and use, consultation and engagement, and review and implementation.

Policy governance: This subtheme relates to how policies are managed within the hospital setting. Participant two, a frontline nurse, explained:

> "The policy and procedure committee doesn't have any representation from people below. It's a real segregated thing. The people who have done the procedures don't come and sit on the committee and then take that information back".

Participants who were members of the policy committee did not express any concerns about the lack of clinical or nursing manager representation on the committee, commenting:

> "It was a pragmatic approach to policy committee membership", and
>
> "[It] would take too long to cover all policies with a broader group of nurses sitting on the committee".

Three participants from the committee expressed views about the challenge of engaging staff in education updates on policy changes and new policies:

> "That despite posters, memos, face-to-face education, e-learning and other approaches, it was still very difficult to raise staff awareness of policies and still needs improvement".

Four participants—three frontline nurses and one NUM—discussed the policy committee as:

> "over-riding feedback provided from clinical areas, creating feelings of frustration and disempowerment in some grassroots staff".

The structure and functions of the policy committee raised views related to how the hospital undertakes policy processes. Three participants in management roles discussed

accountability for development and implementation and evaluation of policies, with two participants with clinical recency viewing this unfavourably and the nursing GM viewing it favourably. The unfavourable views related to issues around loss of control, powerlessness and frustration at the local level in influencing decision-making and taking responsibility for changes to practice. They described that even when they attempt to take ownership and accountability, it is only partially given to them. They supported the GM's view that accountability should be driven from the floor or bedside, but they noted that this often does not occur in every day practice.

Feedback from the participants about the policy committee came mainly from the nurses with clinical recency of practice and the policy committee members. Most participants with clinical recency had a negative view of the assumptions, judgements and lack of understanding regarding what is considered best for policy development centrally. This related to the policy committee membership, including the DOCS, QS team and NE, but did not include any nursing managers or nurses with clinical recency. Six participants expressed favourable views of the policy committee in determining the education needs of each policy based on an assessment of its importance. In this sense, the higher the risk considered for not following the policy, the more extensive and varied the education approaches in order to reach the maximum number of nurses.

This reflected practicality in the frontline staff providing feedback to the committee that was discarded, and the policy or procedure being approved with processes that the frontline staff reported were not practical. An example that was provided related to medication procedures with nursing considerations for specific drugs, in which nurses have to look up the Australian Drug Handbook, as well as MIMs and the nursing considerations procedure, for a drug. They reported that this cannot occur in practice due to time constraints and other priorities.

Access and use: The subtheme refer to access to policies for nurses and how they use them, do not use them or find ways to work around policy processes. Participants reported that

frontline staff ask more experienced staff about a clinical practice or search for local prompts in the form of posters or index cards rather than looking for a policy or procedure document in a hardcopy manual or on the intranet. This was evidenced by a number of examples from their personal experience in terms of the access to and use of policies and related nursing practice. Participant one, NUM, described the approach to medication management and policy in the department. The participant reached behind a filing cabinet and pulled out a small box with alphabetical index cards inside and explained how the index cards work:

> "So, here's my illegal flip cards [laughs], everyone knows I still have them. So, if you were giving a drug, say you want to give say Buscopan [looks up the Buscopan flip card], you can give it via push of IM etc, includes adverse reaction, monitoring etc. I've been told by QS and Executive that I can't have these. There are lots of things in there, so if you were a casual staff and asked to draw up something, you can look at the cards and see how they do it here. They told me that I could have a policy and access MIMS online and the Australian Drug Injectable Handbook, but can't use the cards. But each of those resources have a little bit of information, so you have to look in all three places to see what to do or one flip card".

Participant four, a frontline nurse and acting NE, provided an example of how nurses access information to drive their practice:

> "Junior nurses sometimes will ask what your policy is on this, and you know, then we'll pull up the policy and show them and tell them, but not very often. They tend to just do what they've been told to do. If they are doing anything apart from the basic stuff, you know, we tend to hover around making sure they are doing the right thing, our way".

Six participants viewed seeking information from colleagues as a favourable behaviour; however, two members of the policy committee, one QS nurse and one nursing executive, expressed some unfavourable views about the potential problems with this behaviour because

inexperienced nurses may be seeking advice from peers who also may not have the knowledge and experience to understand the implications. This was based on a general discussion from the participants that showed they do not really know all of the policies in the hospital. Therefore, they tend to practice based on their experience. If someone asks them for advice, they are more likely to relay their practice based on their experience either from their own safety stories or from stories told by other nurses, rather than what the policy may require, which may or may not be based on evidence or best practice. The raises potential issues around roles for coaching and mentoring inexperienced nurses and how experienced nurses can create an environment that encourages curiosity and questioning of practice.

One participant said that it is likely to be inexperienced nurses who seek advice, while others said that it could be any level of experience, as experienced nurses are usually team leaders, and less experienced staff will go to them, and then they may go to the HC, NE or QS. Although participants said that policies are useful for teaching purposes for students and inexperienced staff, there is not a culture or common practice to go to the policy document before demonstrating a procedure or practice, again raising potential issues around roles for coaching and mentoring inexperienced nurses. These perspectives require further consideration through observational fieldwork to explore and understand what actually occurs in every day nursing practice.

Policy consultation and engagement: This subtheme refers to the way in which policies are developed and revised with staff involvement. Two participants generally viewed their consultation and engagement experience with policy in a negative light. Participant one, NUM, outlined how:

> "Nurses working with patients directly generally did not have the time or access to actively participate in the development, testing or evaluating a policy or associated document and were generally cynical about the process".

Participant ten, a nursing executive, described the policy process as a "box-ticking exercise" to meet management or accreditation requirements.

The NUM and frontline nurses described themselves as advocates for frontline nursing staff in terms of providing feedback to the QS team and the policy committee, with half of the participants favourably describing the function that NUMs and level two nurses provide for their staff. Most participants discussed the function of NUMs and level two nurses as trying to make policies relevant for their staff and playing a key role in leading change.

Policy review: This subtheme refers to regularly reviewing policy processes. Six participants discussed the lack of resourcing for nursing staff to participate in policy processes, and management recognised that while it is important and needs to be resourced to be done well, it is in fact not resourced or incorporated into existing work hours. Frontline staff and NUMs are expected to include themselves in policy process engagement as part of their day-to-day work despite there being no allocated or uninterrupted time to review or develop policies, and there is limited access to the online database to search for evidence. Participant five, QS, acknowledged this issue and described a pragmatic approach to policy processes:

> "There's no time given at work to review policies, and we need to be smart about it, choose those who want to do it. You're not going to get a good outcome from those who don't want to do it".

Participant seven, HC, supported this statement, further commenting:

> "It's one of those time-consuming jobs that 99.9% of the time we don't get time to do. I would hope that if someone finds something that is not working that they would speak up and I would imagine on the floor, their first port of call is either their level two team leader or their NUM, you know, they say, 'I found this policy, we don't know, we actually aren't doing it this way anymore but this is what the policy says'".

Participant four highlighted that there are many areas of nursing practice that policies and procedures do not currently cover, and they questioned how it is determined what makes it into the policy database and what is left out:

> "And policies only get reviewed every three to four years, and you know, some things change within that time, if there's not someone within the area that initiates a change, it's not going to come from the quality department because they'll be unaware of it".

One participant, an NUM, described their experience where:

> "policy review could highlight poor practice in existing policies".

This challenges the expert advice and evidence used to develop the policy. Therefore, there are risks in policy development in relation to the appropriateness of evidence and nurses' feedback, and a balance is needed between the reality of day-to-day nursing practice and culture and the need for change in practice to meet desired standards for care and safety. Seven participants discussed how evaluations are undertaken on policies, with all participants reflecting unfavourably on the use of incident reporting as the primary basis of policy evaluation when the incident relates to a policy violation or breach. This reinforced participant one's concerns about the:

> "punitive use of policies to enforce compliance" , and

> "grassroots nurses' fear of the potential for litigation or performance management for not following a policy rigidly or prescriptively".

Ward staff were described by two participants as not having the skills to undertake literature searches and adequately synthesise information coherently to create or provide an informed comment on a policy, despite most nurses now being university-trained. Policies were described as additional to what nurses do in their everyday practice. The nursing staff stated that

their main priority is patient care, and this will always over-ride any administrative work related to policies, which was described as an administrative and bureaucratic burden.

Policy implementation: This subtheme refers to how policies are implemented in hospital settings. Approval is given by the policy committee, and the policy is then implemented without any perceived opportunity for change or "tweaking" to reflect the culture and practices of the workplace, suggesting that once written and approved, policies cannot be easily changed. Frontline participants described:

> "frustration at not being able to test proposed changes because once they were approved there was little chance for change".

Half of the participants explained that it is difficult to identify what has changed in policies when the old and new policy documents are compared. Thus, despite a process whereby the policy committee determines what education to roll out with each policy, it was recognised that the existing methods to raise staff awareness do not work very well. There was a sense of not knowing how to get staff to pay attention to policy changes. One frontline nurse participant stated:

> "that it didn't seem to be relevant to them unless it was directly affecting that at the time, but since most nurses practiced based on their experience or asking colleagues, then they were unlikely to know that there had been a policy change".

The literature highlighted that there is a significant gap in knowledge in relation to policy processes, which affects nurses' practice. Participants reinforced the problematic nature of the policies highlighted in the literature in regard to a lack of awareness of policies, difficulty in accessing them and challenges in effectively applying a broad policy to an individual patient scenario. Participants challenged the universal use of incident reporting to evaluate policy compliance and the lack of incidents as a measure of effective policy implementation. The

literature established that policies and procedures are an essential resource for nurses—in particular, new or inexperienced nurses who are developing skills, experience and knowledge in the breadth of nursing practice. The participants in this study supported this tenet for student nurses, junior nurses, and casual and agency nurses in the workplace. However, the lack of resourcing to support effective implementation, education, coaching and leadership for nurses limits the effect of embedding policies and procedures into every day nursing practice. This will likely undermine the realisation of high-quality care and patient safety at times, and is in contrast to the managerial approach reported by participants that depicts nursing non-compliance with policy as a performance issue to be managed. The novice to expert conceptualisation of nursing skills and experience reflected in works by Benner (1985) were generally supported by the participants, further highlighting the resourcing of and approach for policy implementation as a significant gap contributing to ineffective hospital policy integration into nursing practice.

The theme of policy processes is broad and includes policy governance and the policy committee providing oversight, access and use, consultation and engagement with development, review, evaluation, formatting and implementation. Participants expressed divergent views on how policies are enacted. Four participants discussed unrealistic expectations placed on nurses to have knowledge of a large number of policies, which was described as “overwhelming” at times by participant one, an NUM. This was given as a potential reason for nurses reverting to their past experience and knowledge or asking a nursing colleague. The participant described that it would be very time-consuming to look up every policy related to every aspect of daily nursing practice, and there is not a policy or procedure in place for every aspect of their nursing practice.

Six participants described the excessive amount of information contained in policy documents. QS viewed this favourably because it is an effort to make one policy fit the needs of a broad audience; however, other participants viewed this unfavourably, describing this approach as making some policies unreadable and unrealistic to use in every day nursing practice. Four participants (NE and frontline nurses) recognised that detail is needed to assist students and

inexperienced nurses in learning; however, it is also evident that they are not routinely used for teaching purposes, and the staff are not trained in coaching, mentoring or precepting skills to use such tools and approaches.

4.4.4 Policy Variation or Non-Adherence

This theme refers to how nurses and managers view policies that are not followed, and whether it is a justified variation of practice or considered non-adherence or non-compliance to a policy. Participants explained their perspectives in relation to policy variation where policy is considered a guide to practice, stating:

> "A lot of experienced nurses would have read or learned a procedure many years ago and will continue to do the procedure that way, so a lot of experienced nurses don't even go back and look at a revised procedure. You potentially have more experienced nurses teaching grads or less experienced nurses not the way the policy is, because they are doing it based on historical knowledge. I just think our patients are all so different, you can't make one policy that fits every patient". (Participant four, a frontline nurse and acting NE)

> "The level of complexity at the frontline with patient scenarios can be quite unique. It's like that with every single scenario. It's very difficult for black-and-white thinkers; we can come up with a safe process and sometimes have to have a lot of discussions to get everyone around, because a lot of policies are written for across the board—not for every individual patient". (Participant five, QS team)

Three participants, a NUM and two frontline nurses, discussed the level and type of support from management as promoting a negative focus on using policies, as they are used for punitive or compliance reasons or to force clinical staff to practice or behave in a certain manner. For example, participant one, an NUM, described being:

> "Really hesitant to do anything with these drug policies that I've read. I don't want to put down things and have a fear that if I write that, staff need to do five-minute observations and if they don't do that, then is the hospital going to support them?"

Participant four, a frontline nurse, described the different perspective of QS and frontline nurses around policy, stating:

> "I think that they've lost touch with that, it's become … this is a legal requirement, and it's legally driven, whereas probably I'm more patient care–driven, so I tend to see things differently. Others worry about performance management or getting into trouble".

The QS team described their broad understanding of the policy context in relation to the accreditors, regulators and medico-legal risks with the associated need for policy implementation. They described that they protect nurses and the organisation if nurses' practice aligns with the relevant policies. The team expressed frustration with frontline nurses who do not understand the risks and effects of a lack of policy direction or policy violation or variation in nursing practice, and they felt that they were attempting to help nurses in their everyday nursing practice. One participant reflected on the risk that policy-writers take in relation to the ownership and control of policy processes. This can result in feeling defensive when they are challenged or personalising feedback about their policy-writing, and this can be projected onto other stakeholders involved in the process.

Half of the participants described a fear of litigation or facing performance management processes for violating or varying from the documented policy requirements. This was viewed unfavourably by two frontline nurse participants when used as a punitive approach to enforce compliance with policy and when reporting of variances as breaches in incident reporting processes is encouraged by the local manager and QS. However, this issue was viewed favourably by four participants from management and executive nursing participant groups who discussed the benefits of policy variation based on the assessment and, at times, intuitive sense of

experienced nurses using policy as guidance for nursing practice rather than as rigid rules. Most participants supported this view, whereby policy variation by experienced nurses in order to meet the needs of individual patients and context is considered acceptable and even encouraged when appropriately documented and assessed to ensure optimum safe care, and when policy is deliberately used as a guide to practice.

Three frontline nurse participants favourably discussed the process for escalation to a manager whenever policy variation is needed. This reinforced the view that some nurse's express confidence in their experience, knowledge, assessment skills, competence and advocacy role for patients when applying a general policy to a specific and individual patient context. Discussion of the concept of Benner's (1985) approach to nursing theory of a novice to expert nurse was widely supported by the participants. They described the needs of novice and advanced beginner nurses and sought prescriptive procedures because they did not have the experience or context to draw upon. Competent, proficient and expert nurses then use their experience, knowledge and intuitive senses to plan, assess, implement and evaluate care provision for individual patients. Thus, in this sense, a policy or procedure is used in different ways by nurses with varying levels of skills, knowledge and experience. This is despite the fact that the policy format or document itself may not support a wide variation in practice because it may be written quite prescriptively or as a step-by-step instruction or procedure.

4.4.5 Policy–Nursing Practice Gap

This theme refers to gaps identified between policies and nursing practice. Participant one, a NUM, emphasised that:

> "When you see a nurse practicing differently from the way things were done there, they were challenged by other nurses with an emphasis on patient care rather than referencing policy or procedure documents".

What is written in the policy may be irrelevant to daily nursing practice, and it is certainly different when compared with how nurses actually practice. For example, this participant (the NUM) explained:

> "If you are working a shift and you see someone doing something, you will say, hey, that's not how we do that here, a lot of practices are like that".

Consideration of the themes so far demonstrates the overlap and complexity that is inherent within the concept of policy and nursing practice. Much of the interview discussions with participants related to policy processes. Half of the participants related positive views of staff challenging evidence and best practice in policy development and reviews. This was viewed as a good professional trait in order to challenge the source of evidence to provide a valid argument for change or policy implementation. Issues relating to levels of evidence and variability of evidence were also raised. One participant, a frontline nurse, argued that if there was a national or state adoption of evidence-based practice:

> "We should adopt it even if policy was not in place, as policy processes were very time-consuming to get to implementation stage".

This followed the relating of an experience in which the Australian Resuscitation Council guidelines were implemented by staff in the Intensive Care Unit (ICU) as soon as they changed. However, the policy had taken more than nine months to come around to be considered for revision and updating, so the policy has had no influence on nursing practice, but the nurses in the ICU made a determination to follow the new national guideline. The issue regarding the implementation of national or state standards of guidelines challenges why a policy is developed that simply restates the content from a published standard or guideline. One frontline participant asked:

> "What value did it add to nursing practice?",

or the evidence-based implementation of safe and appropriate care and treatment for patients when nurses are already following the guideline, and with no policy existing or an out-of-date policy existing. Six participants discussed policies in terms of a safety net to ensure that nurses do not forget steps, with two frontline nurse participants unfavourably viewing this driver for policy, which they linked to:

> "a punitive approach for their use and evaluation".

Four nurses with a management role had favourable views of this aspect of policy design, two of whom were QS. A nursing executive and one frontline nurse viewed that this was a positive and important aspect for policies in order to make care safer for patients and nurses. One frontline nurse participant discussed the idea that:

> "some nurses just didn't do what they were supposed to do, and a policy would not change that".

They described experiences in clinical settings whereby:

> "despite well-known policies and procedures, some nurses took shortcuts, did things their own way, and at times didn't care what management said, and may not be mindful about the potential consequences of their behaviours and actions toward patients and other nurses".

Participant four, a frontline nurse acting NE, explained how:

> "Helping nurses at the frontline to understand safety stories and how they related to their everyday practice was a practical way of engaging with frontline nurses and making policy relatable to their practice".

They further commented:

> "Particularly for junior staff, they don't know what they don't know, and, if you can reflect on an event that's happened, I just did a whole lot of coroner's cases with the girls on one of the wards yesterday, just different coroner's cases around Australia, to highlight to them the need to do their observations and to act on their observations to take it further if they weren't happy with what the doctor had done. If you have no understanding of that, and you don't understand the hospital policy that says the patient has a patient-controlled analgesia (PCA) they must have hourly obs, and they don't understand that patients have died from narcotic overdose in the past, that's why somebody instigated a policy on obs."

This challenges the processes around education, clinical leadership and accountability, as well as the evaluation of policies and clinical practices linked to patient outcomes. One participant in QS described clinical staff as having a:

> "Lack of understanding of medico-legal issues and not comprehending the risks that they placed on patients, themselves, other nurses and the organisation in as a result of their clinical practices".

Three participants, a frontline nurse and two nursing executives, discussed the ability of experienced or expert nurses to have an intuitive sense of seeing what may happen and who thinks about the consequences, and they plan for that. This provides a working solution for policy variation, as experienced or expert nurses can draw upon past experience, knowledge, context and an intuitive sense to apply the general policy to the individual scenario in a safe and appropriate manner. This was viewed favourably and as something that should be coached and mentored to support nursing development and practice.

Five participants, frontline nurses and QS, discussed the role of narratives about safety, incidents and adverse events in explaining to nurses why a nursing practice has changed, as well as the use of story-telling, scenarios and case studies in education to explain how policy changes

are integrated into local practices rather than as a hospital-wide education approach. This was viewed favourably, and while the detail of the safety story may fade over time, the key lessons or issues were still told.

Four participants, frontline nurses and QS, discussed the significant challenges in developing a policy that is flexible enough to be applied to individual patients and scenarios. This is something that is not done well, and the staff who write and review the policies at the frontline have no training in how to write them, and they may lack the skills needed to search for evidence and formatting. Three participants discussed which policies they believe are followed, with a view that the less common policies are more likely to be followed according to the documented process if nurses use them. However, the more common nursing practices and procedures are subject to wider variation because nurses tend not to look at them but instead revert to local workplace culture and practice or their own previous experience. They described that nurses in common practice areas are more likely to relate to what they have previously learned or experienced, and this is why they are more likely to relate to other nurses that ask them questions about that particular nursing practice. A recurring statement to the effect of, “I don’t know how others do it, but this is how I was taught” was reiterated by three frontline participants but was said in different ways.

4.5 Analysis

4.5.1 Analysis of Qualitative Context

The findings from phase one of the study have been presented, and a number of themes were identified to explain the phenomenon of the relationship between hospital policy and nursing practice from the perspective of nurses. This study aims to identify, understand and describe nurses’ lived experience of policy processes and nursing practice. Each participant in this study had a different story and expression of language to understand what hospital policies mean to them and how they make sense in their healthcare setting and enact it in their everyday

practice roles. In this sense, language held patterns of meaning as the nurse participants described what mattered most to them—their practice. Hence, where language is used and the world it is used in are closely linked (Wilson, 2014). Each participant's understanding was personal and equally valid within their own context, but it also influenced the culture and context for others in that setting, emphasising the complexity in the everyday practice environment. Exploring the meaning of being a nurse who practices in the everyday space of policy and nursing practice requires interpretation. In this way, the meaning embedded in nursing practice can be shared through observations of practice and shared language to co-construct meaning (Wilson, 2014).

The hermeneutic process sets out to create a fusion between the researcher, who is constantly in a process of formation and interpreting data and context, and the horizon presented by the expression and every day experience of nurses being interpreted (Sharkey, 2001). A new understanding of hospital policy and nursing practice has been created as a product of this fusion of the interpreter and the interpreted, with the researcher and the participants sharing their everyday experiences as nurses. The hermeneutic phenomenological approach provides a framework to describe the phenomenon of hospital policy and nursing practice and how these relate to and affect patient care. This approach helped the researcher to actively engage with the lived experiences and expressions of the everyday working lives of the nurses being investigated (Given, 2008). Reflective processes that are integrated by undertaking research activities culminate in a better understanding of how nurses understand hospital policy and nursing practice, including their role in better understanding the ways of knowing that are accessed by nurses to provide safe and high-quality patient care.

It is important to ask nurses about their experiences with policy and nursing practice to facilitate an understanding of the awareness gained through personal every day experiences in nursing in association with the literature analysed in related fields. The phase one study was effective in meeting this aim by identifying what is known about nursing practice and policy

from the participants in the study and through literature in world, national and local views on their meaning and relationship with hospital policy and nursing practice. A phenomenological hermeneutic approach facilitated awareness and partially met the aim to understand nurses' experiences and every day work. The semi-structured in-depth interviews provided thick descriptions of nurses' experiences of and feelings about policy and nursing practice in one acute hospital setting. The nurse participants were all experienced, each with more than ten years' nursing experience, and across a range of roles, from frontline nurses to nurse managers and executive roles. This phase of the research has confirmed the problem with hospital policy and nursing practice and highlighted the need for further understanding through observations of frontline nurses with different levels of experience on the novice to expert continuum in order to take action in the process of discernment and decision-making around this phenomenon. Although phase one of the study has provided a richness in understanding the voices of nurses in one hospital, there remains a need to further explore and understand the actions and practice of frontline nurses and their relationship with hospital policy and nursing practice in more than one hospital to determine whether the challenges explored and understanding gained are similar or unique to individual hospital settings.

A detailed analysis was undertaken within the hospital study setting to explore and understand the policies and procedures in place within a hospital setting, as well as through database analysis to determine the policies and procedures most frequently accessed by nurses. This summary was reported in Chapter Two. Despite the explicit requirements for policies and procedures in hospitals required by regulators and accreditors in Australia, the number of staff accessing these documents online in the hospital setting under study was demonstrated to be relatively low compared with the number of nursing staff working in the hospital (approximately 400 full-time equivalent nurses). This analysis provided further perspectives that the documents accessed by nurses were primarily procedures relating to clinical practice. Regional policies were primarily administrative and had limited clinical applicability. The participants made supporting

statements during the interviews that although nurses refer to all documents as policies, they are primarily procedural documents that relate to nursing practice. The most frequent procedure accessed over the 12-month period analysed was blood components administration and storage. The QS team explained that following an adverse event in which an incorrect blood product was administered, a review of the blood procedure was undertaken along with a significant education and policy change implementation process, which may have contributed to the large number of times this particular procedure was accessed. The peripherally inserted central catheters (PICC) procedure was the third most commonly accessed procedure during the 12-month period. This was attributed to an adverse event involving a PICC in a patient in another hospital within the group of hospitals, which resulted in a review of the procedure and significant education and policy change implementation process. Given the number of nurses employed in a hospital, the document access history reflected a low rate of policy or procedure access via the intranet, which challenged the researcher to understand whether there are other ways in which nurses gain an understanding of the policy requirements that inform their practice.

Understanding adverse events and clinical incident events was undertaken within a policy context, emphasising the role of policy issues in all significant events reported and in some clinical incidents reported. Nurses self-rated in the incident reporting system that 13% of clinical incidents involved policy as a contributing factor to the incident (the assumption by the researcher following discussion with QS team was that nurses rated a policy that was not followed or evidence-based); however, the contributing factors section of the incident reporting tool was not a mandatory field and may not have reflected the real rate of policy contribution to a clinical incident. The incident reporting database indicated that the highest proportion of clinical incidents was patient falls, at a rate of 21% of all incidents. This further reflects a low level of access of frontline nurses in relation to the most frequently reported clinical incident in the hospital setting. This raised further questions as to what nursing practice occurred with patients that prevented their falls and following a fall, their post-fall nursing management. Analysis of the

incident data alone cannot provide answers to these questions. Further information was sought about how nurses understand how to practice and, when they identify gaps in their knowledge, how they know which nursing practice to provide in order to give safe care to their patients. The analysis highlighted that some nurses are aware of falls risk, prevention and incident reporting; however, there has been limited uptake in relation to accessing the falls prevention policy or associated head injuries observation policy on the hospital intranet. This analysis proposes that there is a relationship between hospital policy and nursing practice that needs to be better understood.

4.6 Analysis of Semi-Structured In-Depth Interviews

Further understanding of the relationship between policy and nursing practice and the extent of the problem with policy was sought by conducting ten semi-structured interviews with nurses as participants in one private hospital. The data obtained were analysed in association with the qualitative context provided to generate meaningful background information to drive questioning and understanding within the interview processes.

It was evident from interviewing each of the participants that the definitional terms for policy and procedure ascribed by the regulators and accreditors were not something that any of them directly referred to or indeed acknowledged in any manner, even those who were responsible or accountable for policy administration. Perspectives on the terminology and application in every day nursing practice were largely referenced to their own every day experiences in their current and past workplaces. The sense of confusion or blurred definition of the terms ‘policy’ and ‘procedure’ were consistent across the majority of participants and were a view that most frontline nurses practiced in the scope of procedures rather than policy in their everyday work. The data on staff accessing policies and procedures in the hospital demonstrated through the most common policies and procedures accessed that procedures are primarily clinically related, and only a small number of hospital policies relate to clinical practice; rather,

they cover human resources, governance and other administrative areas. However, regardless of this context, policy was the generally accepted term used by all participants in their everyday work, even if they are referring to procedures in some cases and policy in other cases. The notion is that policy is a core part of nursing culture, with symbolic and idiomatic expressions in a nursing practice context that focus on the local workplace culture and practicality of policy in nurses' every day work.

The interview and reflective processes brought together the key concepts of local workplace culture and policy practicality as a theme. These concepts were organised around the consistently identified theme that went beyond the meaning of policy as a document. Participants articulated that they believe a policy–practice gap occur frequently; however, the complexity of policy processes and the primary evaluation source of incident reporting make it difficult to understand and quantify. According to participants, the local workplace culture tends to be the dominant driver in defining nursing practice, whereby nurses who observe other nurses practicing outside of the understood or acceptable local practice are challenged. In this way, nurses self-regulate nursing practice within local clinical settings, sometimes as a direct result of policy requirements, but more often as a result of local culture and individual nurse experience and knowledge of safe nursing practice. Participants emphasised that there were large number of policies and procedures to drive safe nursing practice, and that the complexity and dynamics between all parties involved in policy processes was complex and challenging for everyday nursing practice. This highlights the important role of safety stories in nurses' monitoring and correcting practice in an everyday clinical setting. Participants used examples of their own or other nurses' incidents and near misses to coach, educate and caution other nurses about the delivery of safe and appropriate nursing care to patients.

Policy processes related to a range of subthemes articulated how policies and procedures came to be enacted as a documented representation of policy or procedures. These processes include development, format, consultation and engagement with staff, policy committee

functions, implementation and evaluation. Policy practicality is a way of considering how pragmatic the policy process is from the perspective of frontline nurses, and how they apply policy into their everyday nursing practice. Participants provided examples of the large volume of existing policies and procedures and argued that it is impossible for every nurse to know every policy or procedure document in the hospital. Further, the participants challenged the reason or rationality for the various documents required by the regulators and accrediting bodies, with a focus on good and safe patient care by all participants despite their divergent perspectives at times. A negative view related to clinical staff challenging the rationality of change and the policy committee team defending constant challenges from clinicians, who seem to rarely want to change practice even with appropriate evidence, and who question the priority relative to patient care and the frequently stated lack of resources to truly do this well.

The QS teams were the core roles responsible for implementing the policy systems, structures and processes, with the hospital executive accountable within the hospital study setting. This frame of reference was recognised by participants in each group of frontline nurses, nursing managers and executives that were interviewed. Responsibility and accountability for implementation and embedding policy within a hospital setting to align with regulatory and accreditation requirements had some influence on the perspective of those participants and may account for the stronger compliance and power-related subthemes identified in some participants' responses relating to the QS team and executive roles. Participants referenced the high number of policies and procedures required to be in place to meet regulatory and accreditation requirements. Further, there may be other local hospital policies or procedures in addition to those required by regulators and accrediting bodies, adding further complexity for frontline nurses to understand policy frameworks and content.

Participants had some insights into why the QS team or nursing executive may focus on medico-legal and compliance approaches for policy. However, frontline nurses emphasised the practicality of workloads and every day patient care priorities, which showed that many policy

processes are not relevant to most nurses. Nursing leadership and the subsequent effect on local workplace culture was emphasised as an important consideration in the uptake of policy into nursing practice. This was further emphasised by participants in the local culture of how things are done and in the context of nurses' previous experience and knowledge as drivers for practice rather than looking up policies on the intranet to determine what to do locally.

Policy processes were most negatively described by frontline participants. In particular, they described their views on unrealistic expectations placed on frontline nurses and managers to actively participate in policy review and implementation locally, often without any additional resourcing, support or education. In fact, participants described how the policy processes and the implementation of the NSQHSS contribute to a significant increase in the number of policies and procedures, further challenging the implementation and evaluation processes for policy. Participants described the individual manager, educator and leadership approaches to policy processes, and the senior nurses in each department tended to take on the responsibility to provide other frontline nurses to focus on patient care.

The size and complexity of the information provided within policy documents was reported by a number of participants, with some divergent perspectives on how they should be written, for example, as very prescriptive or as a guide to practice. The references to student nurses, junior and new nurses to understand local nursing practice suggested that there was a general predisposition to the quality team, which coordinated and wrote most of the policy and procedure documents to provide a significant amount of detail to cover a broad range of nurses' and practice knowledge. This challenged the considerations of policy compliance versus non-compliance or non-adherence, as the document itself may be so prescriptive that it is not applicable to every patient or scenario. However, participants with clinical recency of practice consistently viewed this clinical incident and adverse event reporting perspectives around policy and procedure compliance as troubling in terms of medico-legal concerns and performance management of nurses. This was highlighted as a consideration by frontline staff when they

reviewed new policies or proposed changes to policy, advocating for both patients and nurses in trying to balance evidence-based practice with practical practice that is achievable in their everyday working environment.

Participants also struggled with the application of published clinical standards when the policy or procedure had not been updated to reflect current evidence-based standards, or when there was no policy or procedure. In practice, participants confided that nurses generally follow the published clinical standards over an outdated policy or no policy, recognising that it can be a long time before policies and procedures catch up to current evidence. This was reinforced by the frontline nurses' view of policies and procedures as a guide to practice that critically thinking nurses can apply based on their applicability to a specific patient scenario, and they can safely vary practice or seek advice as required.

Frustration was expressed by frontline nurses and clinical nurse managers with the policy committee processes, and there was concern about the lack of frontline nurses on the committee. However, the committee member's view was to consult and engage with frontline nurses outside of the usual committee meetings in order to gain their feedback and perspectives. The intent of all nurse participants came from an advocacy perspective; however, the lack of resourcing for policy processes in the clinical setting and the voluminous number of documents in the process cycle posed challenges to the efficacy of policy implementation, access and evaluation. Participants reported many practical impediments to frontline nurses accessing and using policies and procedures. There was resistance when transitioning from local manual processes for easy access to information to a complicated requirement to access multiple document sources to integrate the same information, making the access and use impractical. Where clinical equipment is linked to a procedural document or set up guide located with the equipment, nurses reported that this was highly effective in the clinical setting.

A common statement by participants was that nurses of varying levels of experience ask other nurses for advice on how to perform a procedure, or for help in another area of nursing practice. This could be other nurses on the ward, a team leader, the HC, an NE or a member of the quality team. Reference to policy and procedure written to cover a broad range of experience including students, junior nurses, casual and agency nurses was made by a number of participants. Reflection of Benner's (1982) novice to expert was made by the researcher and discussed with participants, who acknowledged struggling with providing a document that covers nurses across the continuum. There was a consistent focus from participants in this study, who described the process of using policy as a guide to practice through the use of critical thinking processes and professional judgement. This supports Flynn and Sinclair's (2005) view that nurses need some level of experience to even follow a policy, and with more experience they can learn to adapt the policy and use professional clinical judgement not to follow the policy in certain situations. However, this emphasises the need for encouragement, nurturing and professional development of clinical judgement as a core competency in nurses, which was not resourced or part of the education or policy strategy in the current hospital setting.

The policy development or change phase was consistently reported by participants as the most likely period for potential conflict between clinical staff and policy-writers and approvers. This was attributed to the lack of resourcing for this part of the process and an expectation for local engagement without support or education in the process. Frontline participants emphasised that patient care will always be prioritised over what was perceived to be an administrative load of reviewing policies. Feelings of disengagement and powerlessness were described by some participants, whose perspective on policy practicality were disregarded, even to the point of their concerns about patient safety. Likewise, policy-writers in the Quality team expressed frustration at the lack of engagement from nursing managers and expressed that they felt it had become personalised in some cases where frontline nurses did not fully understand the risks to patients, themselves and the organisation.

The concept of policy violation or variation seems blurred when participants can view the same event as either justified variation of safe practice or as a breach of policy. Whether there was a positive clinical outcome or at least no harm to a patient may influence this perspective—in particular, when incident reporting is viewed as the primary measure of policy compliance or lack thereof. The theme of policy variation or violation was identified as an area of high interest and became the focus for opening up the data further. There were two aspects identified in relation to this thematic area, whereby the way in which a particular practice or process has been implemented can be considered by some perspectives to be a variation on policy or by other perspectives as a violation of policy requirements. First, a punitive approach to policy process and second, reasons for varying practice from written policy.

The conditions under which this theme arose were primarily in terms of descriptions of the punitive approach to enforce policy compliance, the direct relationship to incident reporting if a policy has not been followed (generally following an incident) and failure to follow policy. These conditions were identified as contributing factors to the incident or event that occurred. Following policies as they are written can be difficult because there are so many policies, and they contain a large amount of information intended to fit a large staff audience and provide a safety net to ensure that important steps in a process are not missed. A study of guidelines and policies in three central London NHS acute trusts supported this study's findings of information overload from so many policies to the point of reduced compliance and reduced effects (Carthey, Walker, Deelchand, Vincent, & Griffiths, 2011). Staff may break the rules as a result of complexity, following the wrong policy or a lack of awareness that a policy exists, but they are still disciplined if patients experience harm as a result (Carthey et al., 2011). It is suggested that principles for improving policy compliance lay in raising clinicians' awareness of evidence and benefits (Carthey et al., 2011). This may assist in answering the 'why' questions and provide a method for policies to be written to show a practical understanding of real clinical practice by responding to issues of policy–practice gap and policy development and implementation. The

Dreyfus Model of Skill Acquisition had been adapted to provide a model of nursing proficiency from novice to advanced beginner, competent, proficient and expert nurse (Benner, 1982; Dreyfus, 2004). This model reflects a movement from reliance on abstract principles to the use of past, concrete experience as paradigms and understanding a clinical situation as complete when only certain parts are relevant. In Benner's model, novice nurses had no previous experience and were taught about nursing practice in terms of objective attributes to perform tasks that could not be recognised without situational experience and an inability to use discretionary judgement. Advanced beginner nurses demonstrated marginally acceptable performance and had some experience of real clinical situations or aspects. The competent nurse had generally been on the job for up to three years, and they had the skills to plan based on considerable conscious, abstract and analytic contemplation of a problem. They had a feeling of mastery and ability to cope with and manage clinical nursing situations. The proficient nurse perceived situations as a whole, and experience taught them what typical events to expect in given situations and to modify plans in response to these events, with past concrete experiences used to guide their performance. The expert nurse no longer relied on analytical principles such as rules, guidelines or maxims to connect an understanding of the situation to an appropriate action, and they had an intuitive grasp of the situation to resolve problems (Benner, 1982). The application of such a model to the perspectives provided by participants, who through their own experience and competence were competent, proficient and expert nurses, reflected views on policy and procedures that demonstrated a high level of understanding of complex issues, with extensive clinical experience of 20–30 years' each. The participants were able to largely understand the issues and different perspectives based on role and experience, and each participant was confident in expressing their logic and approach to problem-solving. Adding to this knowledge were new insights into why frontline staff practiced other than the way the written policy requires. A theme that participants described was their primary focus on the individual patient and an assessment of their needs, reflecting strong advocacy focus for the

patient. Combined with attributing meaning to policies as a guide to practice, there was a sense that experienced nurses use their common sense, assessment, intuition, knowledge and experience to support decision-making to perform an action in clinical practice that was the safest and most appropriate for the individual patient (Flynn & Sinclair, 2005). However, in promoting this use of clinical reasoning or judgement and patient advocacy as a rationale for appropriate policy variation, concern was raised about the "lack of common sense" (participant four) in some nurses, that "some nurses just don't do what they are supposed to" (participant six) and that sometimes medical staff orders directly "contradicted the rules that a policy dictated" (participant eight).

There was a general sense that the scope of clinical practice and clinical competence supports effective clinical judgement in applying policies as a guide to an individual patient scenario; however, there was a general consensus that nurses do not access policies in hard or soft copy but are more likely to ask a more experienced colleague for advice. This supports another area of general consensus that the local workplace culture directly influences clinical practice, and this is most often driven by the local nursing leaders in a work unit.

There was concern from frontline participants about their perceived imbalance of focus on risk management and medico-legal issues associated with a failure to follow a policy and resultant patient harm from an incident. However, it was difficult to attribute direct causal links from a failure to follow a step or steps in a policy or procedure, and an incident that caused patient harm. The vernacular for patient safety approaches supports a systems focus on clinical practice design and analysis following an incident or adverse event; however, evaluating policy compliance through a failure to follow policies is inconsistent with a systems approach and rests with a person-related issue rather than a system-related issue. Further, there was little evidence of failure to follow policy as a blameworthy act, as defined in RCA legislation in Queensland, that relates to a purposeful act to cause harm to a patient (Queensland Government, 2018).

It is plausible that the participants' explanations of experienced nurses with knowledge and clinical competence working within their scope of clinical practice has had the ability to apply principles of patient assessment and sound clinical judgement. This would enable them to plan, implement and evaluate care for an individual patient and apply policy as a guide to practice, but also vary the steps in order to safely meet the individual needs of the patient. This can be understood in the context of a collegiate environment with a strong local culture and how policy integration into practice is determined by more complex factors than simply the policy document and whether it could be accessed.

Policy and healthcare professionals have been described in terms of converging or diverging trajectories, all with a past, present and possible future (Timmermans & Berg, 1997). Nurses have knowledge and experience in their past. They practiced multiskilling tasks on their shift and pursued workarounds to fit in competing priorities and workloads, which were intertwined with the trajectories of policies and equipment that they used to provide patient care. The different trajectories were integrated into a specific practice, and during this process, the requirements of the policy may have been altered beyond recognition by the staff involved. The concept of local universality with policy or algorithms has been described as a cookbook (Timmermans & Berg, 1997). However, nurses still need to think about their practice with the overarching concept of standardisation based on an underlying sense of domination, which nurses are subjugated to. A study on cardio-pulmonary resuscitation protocols identified that the policy trajectory is aligned but is secondary to that of the clinicians' own goals and trajectory in terms of dealing with local specificities. In a study of the standardisation of protocols, strict policies were rearticulated to provide nurses with some flexibility to practice some discretion and ensure their cooperation, emphasising that their active (but not mindless) support was critical to maintain the policy's trajectory on course (Timmermans & Berg, 1997). The overall stability of the system was challenged and at the same time dependent on the instabilities of the configuration, emphasising the role of nurses who worked as a team to fix each other's

interpretations or deviations from policy. This mirrors some of the participants' comments in this study regarding their local workplace culture and the monitoring of nursing practice from more experienced nurses, which supports the notion of policy as a guide to practice, where critical thinking and professional judgement are inherent in nurses' every day work.

Compliance with policy is continually eroded with a tendency to adjust to the individual nurse's trajectory. Real-time reminders are used as a type of repair or maintenance to keep the trajectory on track, while local variations and cultural traditions are preserved and perpetuated by Timmermans and Berg (1997). This risk was identified with participants in this study when variations were highly dependent on the nurse providing supervision or monitoring the practice of other nurses. Local universality is about how standards manage contested relationships in the workplace while simultaneously being grounded in local work practices and the policy itself is in a constant state of flux where it is managed and manages the trajectories in which it intersected. Universality emerged from this seemingly chaotic interaction of multiple trajectories. The image of bureaucratic control is an illusion, as the multiplicities and contingencies embedded within a policy cannot be controlled (Timmermans & Berg, 1997). Rod and Hoybye (2016) reported on a study to standardise and systematise health practices locally to promote evidence-based practice in Danish health promotion guidelines. The authors analysed practices and outcomes related to implementation of guidelines based on Timmermans and Epstein's (2010) sociology of standards and standardisation, surmising that it is difficult to determine whether standardisation actually occurs in practice. However, the process of standardisation for implementation of evidence promotes a risk factor focus as the key frame for knowledge, reasoning and decision-making in frontline practice. The frustrations raised by frontline nurses about the reality of every day practice are reflected in this study, along with the illusion of policy governance to ensure regulatory and accreditation body compliance.

Power was reflected as contested relationships in policy arising from initial thematic data analysis as highly integrated with other themes. The issues raised around power relationships

were reflected across all levels of nurse participants. Frontline and clinical nurse managers were frustrated with politics and power imbalances by policy-writers and the executive, while policy-writers and nurse executives expressed frustration regarding frontline nurses and managers challenging the policy process and practicality. There was agreement from participants that policies are driven by evidence-based practice, best practice and standards, and they aim to standardise practice in what is recognised as a non-standard and complex healthcare environment. In particular, hospitals are driven by external forces that aim to improve safe and high-quality care, with accreditation bodies, regulators and insurers all driving the development of policies and measurement against standards and performance indicators related to standards. As such, hospital management has responded to this approach of meta-regulation by shifting accountability for policies from downward and attempting to engage upward, which is extremely difficult given the lack of resources provided to fund frontline staff and manager participation in policy processes. The trend in healthcare towards surveiling and regulating many facets of clinical work is potentially incongruent with daily nursing practice. This was not simply about nursing being driven to retain autonomy or a political gambit to retain power. Rather, it was about nurses trying to negotiate a practical way through all of the frontline complexity (Iedema, 2011). This was evident in the phase one study transcripts in the feelings of frustration at management not understanding the practicalities of policy processes and day-to-day practice. There was a need to institutionalise reflective practice to deal with this frontline complexity and a practical way to manage safety in healthcare (Iedema & Carroll, 2011). The authors described an outsider-analyst-catalyst as ethnographer and a reflexive agent, emphasising collaborative decision-making of researchers and participants about what to focus on. They argued that engendering reflexive capacity in clinical staff was critical to confront frontline complexity and to deal with the ongoing issue of contested relationships around policy and practice. The reflexive approach to undertaking this study has enabled nurses at the frontline and in

management roles to engage with the researcher through reflective activities that support the exploration and understanding of the phenomenon of hospital policy and nursing practice.

The lack of resources and overwhelming number of policy areas to provide surveillance over have resulted in a small policy committee with no clinical staff membership in an effort to process the large number of policies required across the hospital in a reasonably timely manner. The trade-off for efficiency in policy processes is a potential challenge to their effectiveness, with a lack of active engagement from frontline staff in all aspects of policy processes. Perceptions of frontline clinical and management staff about the policy committee were reflected in the power relationship regarding over-riding clinicians' feedback, or perceived lack of clinical currency to make informed decisions. Frontline staff expressed a high level of frustration at not being able to test policies and make changes during implementation, as it was often only when the policy was tested in practice that the deficits in the process were highlighted. This concept of loss of control, powerlessness and frustration around decision-making and changes made in policies was expressed by a number of participants.

Culture was reported by many participants to drive practice, and this was seen in the advocacy roles of NUMs to support staff perspectives in challenging evidence or policy strategies with hospital management. A recurrent feeling was reported of the detachment of hospital management from the reality of clinical practice in how policies are developed and implemented, emphasising the problem of a perceived policy–practice gap by frontline staff, but which is not completely supported by hospital management, who are striving to balance the power imbalance from above by accreditors, regulators and insurers.

Complicating this area of policy conflict is the fear of litigation or performance management for policy non-adherence, which were reflected in incident reports as the primary source of evaluation and an assumption from hospital management that if there were no clinical complications or incidents, then the policies must be working. In this case, there was a punitive

approach to enforcing compliance with policies and a dominant theme of risk management or managing medico-legal risk through policy adherence, despite the complexities and ambiguities in policy processes that make up this highly contested terrain.

Nurses are in a good position to provide credible feedback about how a policy will work in practice and how to improve the implementation process (Malone, 2005). The ability of nurses to work around obstacles rather than deal with them directly, a skill they practice on a daily basis when providing direct clinical care, makes it challenging to identify the real issues embedded in the process of policy engagement. This blurred context to policy processes could explain the frustrations between policy-writers and nurses, where the exact problem with a policy is sometimes difficult to identify, or the level of resistance seems to outweigh the issues presented. The process of policy consensus should be more a strategy of bargaining and trading rather than persuasion if it is to be effective in practice (Kingdon, 1984). This infers that political allies and capital are essential in gaining cooperation and support for a policy change or regrouping following failed efforts to push the policy forward to re-evaluate the political landscape and re-establish a strategy of building and leveraging power to engage key players. The ever-present nursing workaround was evident in participants' stories about dealing with policy processes, in particular, as evidenced in the divergent perspectives of participant one (NUM) and participant three (Quality team) around medication policies, the use of MIMS and the Australian Drug Injectable Handbook rather than a local flip card box that had previously been used for medication information.

4.7 Analysis Compared with Literature

The literature review identified a research gap around policy definitions, highlighting the range of regulator and accreditor definitions that all emphasise a top–down approach in integrating them into services. Frontline nurses and nurses in management and executive roles reinforced the lack of acknowledgment of formal definitions, focusing on policies and

procedures as a guide to practice, and procedures as a step-by-step guide. An education, coaching and leadership framework is required to integrate policies and procedures into every day practice, and the literature review also highlighted this gap. These perspectives on what policy means to nurses in their everyday work would seem to be fundamental in order to have a clearer and more explicit understanding and agreement as a foundation to integrate effective policy processes into nursing practice.

Understanding the significance of local workplace culture and change processes is reflected as a gap in knowledge that was identified in the literature review. The effect of the perceived practicality of policy by frontline nurses and clinical nurse managers in particular also affects the culture that nurse leaders create in local workplace settings. According to participants interviewed in this study, this had a significant effect on policy uptake by nurses in their everyday work.

These included accessibility of policies with a change to electronic policy databases and removal of hardcopy policy manuals in an effort to improve version controls and attempt to make accessibility easier. It does not appear to have been successful in the move to online policies based on the participants' feedback in this study. The nursing executive explained that computers are available in clinical areas for nurses to access policy documents online; however, there was good evidence from the qualitative data in this study that nurses favoured seeking out colleagues for advice on policies or reverting to their own prior knowledge and experiences, applying critical thinking skills and making professional judgements. Participants in this study provided examples of policies that are currently in place but are not keeping up to date with changes in published clinical standards, and that nurses tended to follow the most current standards regardless of the local policy statements.

This has provided a further understanding of the phenomenon being studied, namely, the relationship between hospital policy and nursing practice. Exploring the way in which nurses at

each level of the organisation engage with policy in their everyday work has been valuable in gaining a greater understanding of both the effectiveness and challenges in this area.

This study has highlighted where tension has been identified between what was required from a regulatory perspective and what was practiced by nurses in their everyday work. Compliance focus on policy was described as a management approach by nurse participants in the study. Healy and Braithwaite (2006) and Balding (2018) described the responsive regulation environment in Australia, which uses policy to actively manage clinical governance. This was also reflected in Garvey and Palcic's (2016) description of policy that was thought to be in place by management and based on regulatory requirements, but not synthesised into every day practice. In practice, this reality was observed by frontline nurses, but not as clearly by those nurses in management and policy development roles. The preventability of adverse clinical events by policy alone was challenged by Duckett (2016) and highlighted by nurse participants, where continuously improving clinical practice was focused on nursing narrative gained over every day nursing experiences rather than policy.

Complexity in healthcare has been highlighted by authors to support the argument that healthcare is dynamic and unpredictable, leading to unpredictable systems responses and unintended consequences (Atun et al., 2010; Reason, 2004). Hollnagel (2014) described the patient safety approach that focuses on incidents to learn from as Safety I and advocated for healthcare organisations to move towards Safety II approaches, were we learn from what we did well, as this was the more frequent occurrence than what we did not do well. The Safety I and II approaches also highlight the level of complexity that was inherent in healthcare and clinical practice. Clinical governance programs supported compliance with regulatory and accrediting body standards and promoted the participation of the entire workforce in the healthcare environment to improve the culture of safety through policy and effective communication. The implementation of policies was a requirement of NSQHS as well as other regulatory bodies; however, the framework for implementation remains unclear, and it is difficult to provide a 24/7

service. The participants in this study consistently demonstrated advocacy and patient-centric awareness in their descriptions of nursing practice, with the participants in the Quality team and nursing executive more aware of the broader governance and medico-legal concerns and effects for nurses, patients and the organisation. While the frontline nurses and clinical nurse managers had some sense of these clinical governance issues, their focus was unapologetically directed towards the immediate safe care that they could provide to their patients and towards supporting their local workplace colleagues.

The literature review emphasised the top–down and compliance-oriented approach to policies in healthcare organisations. This highlights the challenges of policy as a guide to practice rather than a one-off decision, where there needs to be appropriate processes to safely apply discernment processes of the guide to ensure nursing practice is appropriate for the specific patient situation. This further highlighted the importance of the implementation process through supportive education and coaching nurses to apply critical thinking and professional judgement in complex clinical situations for the best outcomes for their patients. The emergence of interconnectivity of health practitioners and care processes to support a coherent policy implementation and change process within distributed decision-making networks is highly complex, highlighting that there are many areas of nursing practice that exist policies and procedures do not cover. A bimodal understanding of policy compliance or non-compliance seems insufficient to adequately explain or understand what occurs in the relationship of hospital policy associated with every day nursing practice.

The perspectives of management and policy development nurse participants focused more on supporting the regulatory and managerial lens of policy in clinical governance. The frontline nurse participants highlighted divergent perspectives from management colleagues and a further understanding of the views and experiences of a broader sample of frontline nurses to understand the relationship between hospital policy and nursing practice in every day nursing practice.

4.8 Analysis of Comparison with Study Aims

The aim of gaining an awareness of the relationship between hospital policy and nursing practice was achieved in phase one by identifying what was known through nurse participant perspectives and thematically analysing and comparing this with the current literature. The second aim, to understand nurse' s experience and everyday work, was partially achieved through experienced nurse participant perspectives recounted to the researcher. However, analysis of phase one highlighted the need for further interpretation and understanding of the phenomenon through direct observation of frontline nurses with different levels of experience. This approach aims to facilitate a process of in-depth understanding and discernment around this phenomenon. The third aim of phase one was to describe the relationship between hospital policy and nursing practice that promotes discernment and decision-making to ensure patient safety and high-quality care. This aim was not sufficiently achieved, as the methods and participant selection provided perspectives and experiences of ten nurses, which highlights the need to explore understanding directly from a broader range of frontline nurses.

Thus, a second phase of the study is required to obtain a better understanding of frontline nurses' experience in their everyday nursing work. Phase two will enable the researcher to fully achieve the study's aims of creating awareness and understanding and describing the relationship between hospital policy and nursing practice.

4.9 Conclusion

The phase one study findings have shown that there is a problem with the relationship between hospital policy and nursing practice. This was evident from the voices of nurses within one acute hospital setting, and in the analysis of documentation relating to policies, adverse events and clinical incident management. Further, this part of the study identified themes that provided an introduction to moving from an awareness of a problem with policy to beginning to understand the problem in greater detail.

The informal or 'behind closed doors' approaches of dealing with policy and practice, as well as learning from incidents and near misses at the frontline of clinical practice, were limited by the study method of semi-structured in-depth interviews. Participants' views could be heard and reflected upon by the participants and the researcher, but not observed to fully grasp the breadth of understanding that may be required to describe the phenomenon of the relationship between hospital policy and nursing practice, and to elucidate a path forward. The interview processes were subject to interpretation by the participant in what they were willing to share with the researcher, and then by the researcher in interpreting and reflecting on the information shared by the participants.

Further opportunities were identified for research in exploring the contested relationships around hospital policy and nursing practice in a clinical setting. The way in which a particular practice or process is implemented can be considered by some perspectives a variation on policy or by other perspectives as a violation of policy requirements**.** This was supported by Iedema (2009), who emphasised that safety cannot be bureaucratised into practice, and there is a need to consider the complexity of in-situ work processes and be vigilant against predetermining clinical practices. The thematic analysis of issues around policy practice and power is implicit within the contested relationships of variation or violation and provides a layer of complexity, as emphasised by Kingdon (1994), that cannot be disassociated from the relationship and processes. Nor can it be separated from approaches to clinical reasoning or judgement and patient advocacy as a rationale for appropriate policy variation. There was further research potential in this area of contested relationships of policy and practice, particularly in consideration of different nursing skills and competence levels, and varying workplace cultures.

Mapping this work across nursing practice and patient care areas with a focus on the practice of frontline nurses would provide valuable insights into this research area in practice by building nurses' capacity to deal with policy and practice complexities in a meaningful and practical way. The phase one study demonstrated contested relationships between managers as

policy developers and nurses as policy users. This emphasised the importance of frontline nursing staff and managers working together to develop skills and flexibility in continuous critical reflection of their own practice and processes, and to develop a shared understanding of policy and practice relationships and issues. Consideration of in-situ approaches to handling policy and practice approaches in nurses across the continuum of novice to expert skill and knowledge acquisition and development was important to understanding the role of policy in every day practice. Benner's (1982) perspective was an important part of the discourse to understand and develop in a complex reflexive space with opportunities for research that encourage participative engagement (Iedema & Carroll, 2010).

A phase two study is planned to explore and understand this contested terrain of hospital policy and nursing practice at the frontline of nursing practice across three acute hospitals. This inquiry extends into a second phase of study to enable the researcher to observe what nurses do in their daily work in relation to policy and nursing practice. Undertaking further research using methods that present opportunities for the researcher to experience the same events as the participant, working with participants and facilitating a process of joint reflection on nursing practice is envisaged to facilitate a greater understanding of the relationship between hospital policy and nursing practice. This will assist in providing new and shared understandings about what nurses think and feel about policy and nursing practice in the phase one analysis, and then observing what they do or how they act in relation to policy and nursing practice in phase two of the research study. It emphasises reflexive and collaborative methods using a broader sample size of nurses in targeted areas in three private hospitals.

Chapter Five: Methodology and Methods—Phase Two

5.1 Introduction

The previous chapter presented phase one of the research study, in which a hermeneutic phenomenological approach was used with semi-structured in-depth interviews with nursing participants. This aimed to explore and understand the relationship between hospital policy and nursing practice. Reflective practice was integrated into the research methods to support interpretations of the nurse participants' perspectives as well as that of the researcher.

5.2 Aims

Phase two of this study aims to explore and understand the contested notion of hospital policy and nursing practice from the perspective of frontline nurses across three acute private hospitals. This phase enables the researcher to understand not only what nurses think, but also to observe what nurses do—that is, how they practice in their daily work in relation to hospital policy. Thus, the aims of phase two of the study are to:

1. develop an understanding of the relationship between hospital policy and nursing practice by observing how nurses with a range of experience practice in an everyday work setting
2. describe the relationship between hospital policy and nursing practice that promotes discernment and discussion towards improving patient safety and ensuring high quality of care.

These aims emphasise that frontline nurses play a critical role in every day nursing practice and are important in helping to develop an awareness and understanding that can promote a discussion of the nature of hospital policy and nursing practice. This opportunity to work directly with the participants and facilitate a process of joint reflection on hospital policy and nursing practice will add a greater understanding to this relationship.

The approach of understanding hospital policy and nursing practice, such as learning from incidents and near misses or observing nurses practicing in their own work environment, was limited by the study method in phase one of the semi-structured in-depth interviews. The interview processes were always subject to interpretation by the participants in terms of what they were willing to share with the researcher, and then by the researcher in interpreting and reflecting on the information shared by the participants. Participants' views could be recorded and reflected upon with participants and the researcher. However, in phase one, it was difficult to grasp the breadth of understanding fully for frontline nurses that may be required to adequately describe the phenomenon of hospital policy and nursing practice. Particularly, as the views of the participants made assumptions regarding the needs and perspectives of junior frontline nurses and student nurses. These groups of nurses were not reflective of the participant sampling in phase one of the study.

Safety cannot be administered into practice through policy alone, and the need to consider the complexity of in-situ work processes and vigilance against predetermining clinical practices was emphasised (Iedema, 2009). The thematic analysis of issues around policies, practice and power was implicit within the contested relationships of variation or violation and provided a layer of complexity that could not be dissociated from the relationship and processes (Kingdon, 1994). Nor could it be separated from approaches to clinical reasoning or judgement and patient advocacy as a rationale for appropriate policy variation or non-adherence. As such, there is further research potential to understand and discuss this area of contested relationships between hospital policy and nursing practice, particularly in consideration of different nursing skills and competence levels and varying workplace cultures.

Exploring this work across nursing practice and patient care areas in a future study will contribute valuable insights to this research area and build the capacity to explore and understand practice complexities in a meaningful and practical way. Consideration of the in-situ approaches to handling policy and practice approaches in nurses across the continuum of novice to expert

skills, knowledge acquisition and development is an important part of the story to understand in a complex reflexive space with opportunities for research that encourage participative engagement (Benner, 1982; Iedema & Carroll, 2010).

Phase two therefore aims to explore and understand this contested terrain of hospital policy and nursing practice at the frontline of nursing practice across three acute hospitals. This inquiry will enable the researcher to observe what nurses do in their daily work in relation to policy and nursing practice. Undertaking further research using methods that present opportunities for the researcher to experience the same events as the participant and to work with participants to facilitate a process of joint reflection on nursing practice will facilitate a greater understanding of the relationship between hospital policy and nursing practice. This will assist in gaining new and shared understandings about what nurses think and feel about policy and nursing practice from phase one. Phase two facilitates observations about what nurses do about policy and nursing practice. It emphasises reflexive and collaborative methods using a broader sample size of nurses in targeted areas in three private hospital settings.

5.3 Methodology

5.3.1 Paradigmatic Approaches

Phase one of this study provided an outline of the paradigms used to undertake the research. The epistemological and ontological aspects of the research approach described in the phase one methodology are important foundations for developing a methodology for phase two that can explain strategies for collecting and analysing data in a research study (Tracy, 2013a). The epistemology provided context for how the relationship between hospital policy and nursing practice came to be known in the research study. It emphasises that the researcher and participants bring their own assumptions and beliefs, which are sometimes reflected in explicit ways and other times revealed through reflective practices that uncover previously subconscious information relevant to the study and through a clinical governance lens. The ‘insider–outsider’

approach by the researcher continues to reflect the roles that the researcher uses to engage with participants, form relationships and remain alert to multiple ways of viewing and understanding the relationship between hospital policy and nursing practice. A key perspective for this study is influenced by the role that the researcher played in the study settings, where interest in the relationship between policy and nursing practice was raised and questioned by the researcher in both research and employment role capacities. This relationship between the researcher and the research continues to be an important consideration in understanding this epistemological stance through the clinical governance lens to explore the nature and reality of hospital policy and nursing practice. Through this constructivist and post-modern paradigm, there are many realities to explore across nurses with a range of experience in different hospital settings.

The ontological approach in constructivism described in phase one continues to be a critical part of the post-modernism perspective of negotiating reality (Sandu & Unguru, 2017). This validates the qualitative research design approach, where seeking to make visible the notion of what hospital policy is or is not, and how nurses experience hospital policy in their everyday work in providing care to patients, is possible through their experiences as well as those of the researcher experiencing the same events in the field and exploring each perspective of the experiences. The awareness of personal assumptions and biases, the complexity and multiple viewpoints at work in a healthcare setting, and the journey of understanding different perspectives, truths and opportunities to obtain new knowledge about the phenomenon of hospital policy and nursing practice remains an important consideration for the research design.

The ‘insider–outsider’ researcher roles afford access, trust, entry and some common ground to commence the research; however, in phase two, the nurse participants will be unfamiliar with the researcher. This provides greater potential for breadth of experience in the ‘insider–outsider’ roles for the researcher, highlighting the necessity to construct methods that facilitate reflexivity, which challenges the researcher’s assumptions and potential influence on data collection and analysis (Burns et al., 2012; Corbin, Dwyer & Buckle, 2009).

Ontological and epistemological approaches are inter-related in helping to understand the purpose of hospital policies and their usefulness and application in nursing practice. This raises a consideration that multiple realities and perspectives are inherent in the construction of concepts around how nurses make sense of hospital policies (Carter & Little, 2008). This emphasises the need for a consistent interpretive approach and reflecting on practice during the research process to ensure the meaningfulness of the study's findings. Reflection approaches involve trying to understand the narrowness of the researcher's own perspective and actively seeking alternative viewpoints. Reflection takes into account the situated nature of knowledge, where the researcher's reflection of their perspective in the process of interpretation is an important contribution to the study perspective (Walker, 2011). Reflection is a study method in a sense that is central to support the methodological approach. On this basis, understanding the nature of reality in the study context is important in this ontologically complex study setting (Denzin & Lincoln, 2011). There are expected to be multiple viewpoints, and the nature of the study will still be limited to describing what is observed and understood from the experiences of the participants in the particular study settings and around their relationships with hospital policy and nursing practice as defined by the aims of phase two. Reflecting on the nature of reality through the clinical governance lens, the research is positioned within post-modernism and constructivism in this study. These paradigms provide an approach to organise the complexity of both epistemological and ontological decisions about the research design (Denzin & Lincoln, 2011).

5.3.2 Post-Modernism and Constructivism

The tenet of post-modernism is that realities are constructed within a specific political, historical and social context. These realities are not static but are always being reformed, constructed and deconstructed with no single reality or truth and related knowledge to power relations (Foucault, 1977; Liamputtong, 2010). The post-modern approach to power and knowledge relating to policies argues that it is unstable and has many realities, highlighting

moments of domination, self-subordination and accentuated resistance and change (Tracy, 2013a). From the researcher's perspective, this infers a shift from a purely objective outsider or observer to one who is intimately involved in the research as an 'insider', and it emphasises the researcher's involvement as part of the understanding of the world, and where the voices of the participants are privileged as an authority to the text and knowing produced through the research process (Ramaekers, 2006). How this is represented in phase two of the study is unknown, as the researcher will be subjugating participant selection to the local workplace nursing managers because the researcher has no prior relationship with the nurse participants. The tensions highlighted around formalism and power relations between nurses and management is an important consideration in this space (Rossignol & Hommels, 2017). The relationship between participants and the researcher is expected to raise considerations about power relations and hierarchy that require authentic and detailed reflexive approaches and analysis of the effect on data and interpretation.

The outcomes of this study for both phases will make the often invisible and sometimes banal subject of hospital policy and nursing practice a subject of discussion and challenging perspectives and will contribute to the debate on the relationship between hospital policy and nursing practice. This continues to place the concept of practical wisdom at the centre of the research process, and the observation and discovery of the unfolding phenomenon could fuel action as another way of thinking in the everyday work of nurses (Rolfe, 2006).

Clinical wisdom is demonstrated by nurses who are experts in their roles. It describes nurses with the skills and knowledge to respond to their patients' care needs out of experience in their practice rather than relying on rules or policies. Approaches to nursing practice are described by Benner et al. (2009, 2011) to understand how nursing narratives can demonstrate and make visible experientially acquired knowledge, skills and ethics that are embedded in every day nursing practice. The retelling of nursing stories around exemplary practice or where a breakdown in practice results in subsequent learning were initially explored in phase one of the

study (Cathcart & Greenspan, 2013). However, the methods in phase one limited conversation from frontline nurses about the forms of knowledge, relationships, judgement and discernment embedded within their stories to generate further reflection and refocusing on nursing practice.

Phronesis is described as the practically wise nurse being motivated to pursue safe and good-quality patient care and to understand what they must learn and know to contribute to the safe and effective practice of care for their patients (Sellman, 2009; Jenkins, Kinsella & DeLuca, 2019). This was reflected with the experienced nurse participants in phase one. This means that these nurses deal with the dynamic nature of their everyday work environment and their own development as a nurse, which cannot be reduced to simple or prescribed responses to the situations they face in their everyday work (Sellman, 2009). This reinforces the significant role that self-awareness plays in this practical wisdom or nursing phronesis for nurses to know when they require further knowledge or skills to practice safely. Phase two of the study will provide the researcher with a greater scope to engage with nurse participants to explore and understand this aspect of self-awareness in relation to phronesis and the effect on their experience with hospital policy.

A main tenet of constructivism is that nurses are actively creating their own knowledge, and their professional growth is attributed to sharing perspectives and changing internal representations through ongoing nursing practice experience and learning (Brandon & All, 2010). Constructivism operates upon key assumptions, including knowledge, assimilation of new information, critical thinking and reflective practice (Brandon & All, 2010). Phase two of the research provides opportunities to validate these assumptions with nurse participants in their everyday work. The research approach is then enacted with an explicit framework that integrates post-modernism and constructivism through a lens on ways of knowing in a clinical governance context. In this regard, methodological approaches derived from ethnography are undertaken to support the methods, data collection and analysis in this research study. Holloway and Wheeler (2010) described ethnography as an approach used to study and describe human behaviour

through contextualising cultural norms and routines such as those observed by frontline nurses in relation to hospital policy and nursing practice. The researcher, as a nurse, has knowledge of healthcare language and the setting, and is aims to typify nurses working in settings and interacting in clinical practice (Holloway & Wheeler, 2010).

5.4 Ethnography

Phase two of this study supports an exploration of nursing cultural relativism through an ethnographic approach undertaken in three different hospital ward settings in three different hospitals. This will provide a better understanding of nurses in their everyday work when practicing nursing in their own social and cultural contexts—namely, their hospital ward setting. Ethnography has been described as the study of culture in social settings (Liamputtong, 2010). Culture references the:

> "meanings and practices produced, sustained, and altered through interaction" (Van Maanen, 2011, p. 155).

This approach supports the researcher to view all aspects of hospital policy as processes and parts of an integrated whole, where an observational, 'insider–outsider' approach and reflexivity can be further used to immerse the researcher into the workplace culture of relationships through fieldwork processes. This aims to generate richer and thicker descriptions of the observed relationships between hospital policy and nursing practice (Daly, 2007; Liamputtong, 2010).

Ethnography is a philosophical paradigm influenced by phenomenology, hermeneutics and post-modernism (Angrosino, 2007; Gobo, 2008). Ethnography and phenomenology are research approaches that characterise the application of qualitative research and use interpretive methods to understand the phenomenon and meanings through participants (Mol, Silva, Rocha, & Ishitani, 2017). The open-ended nature of fieldwork is a critical aspect of ethnographic study. While fieldwork is structured around research questions and priorities, it requires as much, if not

more, non-directed engagement in order to be aware and open to experiencing both significant events and mundane aspects of everyday life of the participants and the culture under study (Trnka, 2017). Methods of capturing information and exploring how participants make sense of their work in their everyday circumstances are important in studying ethnography (Liamputtong, 2010). Where the researcher becomes an ethnographic storyteller, the fieldwork and methods are aimed at learning from participants and cultures rather than simply studying people, and the closer the researcher comes to understanding the participants' points of view, the greater the story (Fetterman, 1989). Ethnography has also been described as an account of how the world experience could come to be known in common by others, as a way of describing the unfolding of people's everyday lives (Smith, 1974).

A key concept of ethnography is the assumption that knowledge is socially organised and that perspective is subject to one's location in the organisation, in the person's standpoint (Smith, 1987). The rule relations described by nurses explain how their actions are often beyond their consciousness, and that the power relationships introduce tensions (Smith, 1987). In this sense, ethnography avoids categorising, theorising or reconceptualising nurses' experiences (Smith, 1999). However, it tracks nurses' work and every day activities and explores the empirical links that explain what is happening in order to build a practical account of what has happened and determine how work is coordinated across different social positions. Modern ethnography largely focuses on understanding local communities and cultures rather than far away and exotic ones (Draper, 2015). In this sense, ethnography in this thesis focuses on the everyday work of nurses to understand hospital policy and nursing practice in day-to-day routine nursing practice situations.

In this study, the voices and experiences of frontline nurses have been privileged, as their attitudes and experiences influence how they respond to the researcher and make meaning of practice. The ethnographic approach aims to explore and describe these meanings, which, by its nature, acknowledges that there is no universal knowledge. If we are not able to understand the

relationship between hospital policy and nursing practice through the lens of frontline nurses, we risk developing practice and policy that are misunderstood, or worse, misdirected.

Hospital culture is a dynamic context with which nurses engage in the complexities of their everyday work (Draper, 2015). In this context, ethnography is a process of understanding hospital and nursing culture through rich descriptions and details of the everyday work of nurses (Draper, 2015). In particular, ethnography takes the familiar aspect of hospital policy that is so normalised by nurses and managers that we may fail to recognise the effect on nursing practice. It is important to understand how the individual and society inform and are informed by each other (Draper, 2015). These approaches affect the methods chosen to explore and understand the nurses' perspective, as well as the larger collective perspective where both of these perspectives are an important part of understanding cultural practice, and where the individual shapes the collective and the collective shapes the individual (Draper, 2015). The researcher's influence is impossible to remove from the ethnographic study because it is a study of the world, which necessarily includes the researcher (Draper, 2015). In this way, ethnography embraces the influence of the researcher as both explicit and necessary (Cruz & Higginbottom, 2013). The researcher is a key instrument of data collection and therefore plays as significant a role in the research as the participants (McGarry, 2007). Reflexivity is thus considered a central method inside ethnographic research and is integrated into each of the methods in this study.

Methods for data collection were chosen to reveal social and cultural practices and their associated meanings by participants in the study. Data were collected from nurse participants who are representative of the culture under study. Participant observation requires the researcher to observe the culture directly, and the researcher is able to make their explicit 'insider' and 'outsider' status known during the study and reporting phases of the study (Cudmore & Sondermyer, 2007). The research information kit and related posters and information briefings provided to participants in the study setting enables consistent and broad dissemination of the researcher's role and research purpose.

In observing nurses caring for patients, ethnographic researchers explore how abstracted categories and theoretical categorisations organise people's knowledge and their work. Fieldwork reveals how nurses punctuate each patient encounter with time spent on the computer, where the patient–computer–patient processes dictated what nurses paid attention to. Standardised records and flow sheets, and general text–work–text processes keep nurses to a schedule of gathering information from and for each patient's record. These encounters will be observed during the fieldwork and incorporated into the reflexivity processes.

Some nurses experience tension between the ideology of patient-centred care and the organisationally captured organisation of their work (Smith, 2006). The processes and systems introduced into nurses' work often proceed unchallenged as advancements in care provision rather than what is going wrong in nursing. Balancing the tensions between paperwork and patient care creates further challenges for nurses trying to follow the rules while ensuring safe and appropriate care on a busy medical ward (Smith, 2006).

This ethnographic approach seeks to understand culture through thick or rich descriptions in terms of detailed descriptions of everyday life and studying how nurses and their patients live in every day contexts (Cruz & Higginbottom, 2013; Hammersley & Atkinson, 2007). In describing culture, ethnography is concerned with things that are taken for granted—those things that are so ingrained that they are invisible, and we may fail to recognise the individual or collective experience and effect. There is an interplay between the individual (the insider's perspective or the reality seen, felt and expressed by the nurse) and the societal (the larger collective or social picture) and how they inform and are informed by each other. This is the space where the banal reality of policy and nursing practice rests. More research must be undertaken when nursing occurs, and in that space nurse researchers can find themselves in an alternative world in which they can view the same environment from a different perspective (Cudmore & Sondermyer, 2007; McGarry, 2007). As such, fieldwork undertaken in an ethnographic study creates an opportunity to get to know the people involved in it in a new and

intimate way through participant observation methods and a systematic approach to recording observations and learnings while participating in the everyday lives of the participants. This makes the methods undertaken important in understanding the participants' social world and phenomenon under study in ways not previously understood.

5.5 Ethical Considerations

Ethical considerations for this research study are encompassed in the formal process of ethical review and approval through the healthcare organisation. The second phase of this study involves observational fieldwork in which the researcher observes nurse participants, patients, nurses and managers in their interactions with the nurse participant. This required a new NEAF application to consider the potential ethical effect of the study on all potential parties impacted, and a review of the associated information kit and information provided to participants and other parties. A phase two NEAF application was made to the organisation's human ethics and research committee, and approval was granted in June 2013 on the basis of meeting NHMRC ethical guidelines (see Appendix B for ethical approval for the phase two study).

A poster about the research and provision of the PIK was made available to all potential participants and NUMs in each study setting. These kits included information on the research, researcher reflective and explained that participation was voluntary and participants could withdraw at any time without repercussions for their work or working relationships. It was also reiterated in the kits that any concerns about the researcher or research could be raised with the chairperson of the HREC directly, with contact details provided.

5.6 Methods

5.6.1 Insider–Outsider

The researcher was involved in observational fieldwork that posed challenges in balancing the dual roles of insider and outsider researcher and emphasised the tension that arose

between fostering a trusting relationship with participants, other nurses, managers and patients, and establishing sufficient distance from participants to make sense of observations (Bonner & Tolhurst, 2002). The nurse participant cohort involved in phase two of the study did not have prior knowledge of the researcher; thus, the researcher was viewed as an 'outsider' buddying with a nurse in the ward. However, as the researcher has a good understanding of the wards and culture being studied, there was an 'insider' aspect to the researcher's role. This was reinforced when the manager or other clinicians passing through the ward recognised the researcher and engaged in conversation, reflecting to the participants that the researcher was known and trusted by other nurses, doctors and senior leaders.

The same insider perspectives relating to knowledge of where to access organisational information, databases, organisational structures and routine practices were relevant in both phases of the study. This facilitated the gathering of rich data and also provided risks where the closeness to practice, from a clinical governance perspective, could pose difficulties where practice inconsistent with hospital policies was observed. Closeness to practice could also challenge the researcher to identify behaviour or practice that was taken for granted and not seek further information, a risk previously posed in the phase one study. This is where thoroughness in documentation of observed practice and reflection are an important aspect to consider in the methods undertaken.

5.7 Observational Fieldwork

To work as close as possible to the participants, the researcher made plans to work alongside the nurses during a range of shifts to observe and document their nursing practice and relationship with hospital policy in an everyday working environment. These buddy shifts, as the ward NUMs referred to them, were planned to be followed up with a one-day reflective practice session between the participants and the researcher. During this session, the transcripts and initial

analysis of the data were shared for an open discussion and reflection on the shift, and the relationship between hospital policy and nursing practice.

Undertaking buddy shifts with the researcher working alongside the nurse participant was proposed as an effective approach to establish some familiarity between the researcher and participant and promote engagement. This was undertaken by assisting in nursing care activities such as hygiene care, making beds, mobilising patients and assisting with basic nursing care. The researcher also reinforced to participants through the PIK, A4 poster and discussions that they had successfully undertaken current basic ward competencies including basic life support, manual handling and hand hygiene. This established some basic credibility and rapport as a nurse who had been accepted to safely work on the ward as a buddy to the participant in order to assist them in their work for the shift.

The Chief Executive Officer (CEO) supported the researcher by funding the fieldwork, so there were no additional costs in the clinical setting. This assisted the researcher to undertake the fieldwork with nurse participant shifts involved the in research funded by the CEO cost centre. The ability to involve frontline nurses in research at no cost to the local cost centre was a positive consideration of involvement in the research process by the NUMs. The researcher requested the NUMs of each medical wards to pre-allocate patient loads the day before the buddy shift. The researcher also requested that the NUM allocate the nurse participant and researcher to patients that had capacity to provide or decline consent to the researcher. This meant that the researcher required that that were no patients included in the allocated area with cognitive impairment, under the age of 18 years, or that otherwise requires a substitute decision-maker to consider consent. The NUM was also asked to provide a copy of the A4-sized research poster that outlined the research to patients and staff working in the allocation area, explained the research and sought their verbal consent. The researcher planned to arrive on the ward 30 minutes before the usual shift start time to meet with the manager and participant nurse to confirm that it was still suitable to buddy with the nurse on the shift. The researcher also wore a

hospital uniform and identification badge, with an additional ‘nurse researcher’ badge worn in prominent position at chest level to ensure that staff, patients and visitors were aware that the researcher was working on the ward as a nurse researcher for the shift. This was not an explicit requirement from an ethics or hospital policy perspective; rather, it was researcher-initiated in order to provide maximal transparency and openness to the patients, any visitors and ward staff during the fieldwork periods. This was proposed to also provide an opportunity to clearly identify the nurse researcher role for that shift, as opposed to the researcher’s usual role in the organisation as Director of Clinical Governance.

Additional copies of the research information kit and the A4-sized research poster for staff and patient information were provided by the researcher and available on the ward for the shifts worked. The researcher planned to note the patients that were allocated for the shift and visit each patient prior to the shift commencing to provide an A4-sized poster that outlined the research and confirmed with the patients that they were aware of and consented to participating in the research. Through their verbal consent, patients could agree to the researcher buddying with their nurse to observe their nursing practice for the shift as part of the research. This provided an additional opportunity for observation of nursing practice ‘behind closed doors’ in patients’ rooms, which enabled the researcher to observe all nursing practice during the shift rather than only what could be observed from the corridor or nursing station. This was an important consideration for the observational fieldwork because it helped the researcher to understand nursing practice and if there were conversations or other activities that explained how nurses shared their practice knowledge with each other and their patients. Reflective activities on the fieldnotes generated from these experiences were considered important by the researcher to undertake in the follow-up reflective sessions between the researcher and the participants.

As an insider–outsider nurse researcher, having an existing professional and organisational relationship with each NUM was intended to assist in the participant selection and consent process. Further, the logistics of arranging patient awareness and consent was important

for open communication and transparency throughout the study period. It also meant that on the day of working the buddy shift with the participant nurse, the shift started out as usual with end-of-bed handover and huddles, because the consent and participation processes had been dealt with. This was important in enabling the researcher to observe the shift as it usually started, how it operated throughout the day and how it concluded, and also to minimise interruptions to the usual workflow undertaken by nurses in the ward setting. There was a risk that without a well-coordinated research process, this important administrative part of the research process could have created an unfavourable starting point for the fieldwork.

After working together on the buddy shifts with the researcher to undertake observational fieldwork, a follow-up reflective session was planned between the researcher and the participant within the following fortnight outside the ward environment to minimise disruptions to every day practice. This was aimed at giving the researcher and participant an opportunity to review the researcher's fieldnotes and reflect on nursing practice that emerged from the buddy shift as exemplars demonstrating the everyday reality of the relationship between policy and nursing practice.

5.8 Reflective Practice

A summary of the researcher reflection included in the PIK set the scene for the participants to understand context and meaning about the study and the researcher. Recognising that active participation in fieldwork means that the research will impact on the researcher. Sharing fieldnotes and reflective diarisation with participants aims to provide transparency between the researcher and participants and to expose the many voices and perspectives for consideration and discussion. Analysis in ethnography is a reflexive activity that commences at the outset of the study with the generation of the research problem and questions throughout the data collection phase and into the reporting phase. In this manner, reflexive processes undertaken

throughout the research process enhance the analytic rigour of the study (Murphy, Griffiths, & Merrell, 2014).

The model of reflection used as a basis for the researcher's and participants' reflection in the phase one study was also used in the phase two study. This involved an approach that provided cues to assist nurses in reflective processes with the aim of sense-making and learning through experience (Johns, 1994). This model, as previously outlined, focused on four areas: description, reflection, influencing factors and learning. This was considered a practical way to work with each participant to reflect on the observational fieldwork brought forward by the researcher and to provide a framework for the participant to discuss, make sense of and learn from their experiences. This reflective process is an important part of the methods used in this study to provide a structure or framework to support the review of the observational fieldnotes and as a focal process for discussing vignettes identified in the description phase of the process. The description phase will provide an interesting opportunity to open up the nurse participant to what they did and said during their eight-hour shift. A reflective process checklist has been developed to utilise throughout the research process in phase two to assist with reflectivity and analysis processes.

Following the observational fieldwork, a follow-up reflective session between the researcher and participant occurred for one eight-hour shift within the following fortnight. This provided the researcher and participant with an opportunity to review the researcher's fieldnotes and reflect on vignettes or nursing practice that emerged from the buddy shift as possible exemplars of the relationship between policy and nursing practice.

Analysis of documentary evidence was included in the reflective sessions with the participants. This was proposed to include a review of the policy database records to determine participants' access to policy or procedure documents online, and auditing was undertaken with the researcher and nurse participants of medical records and nursing practice related to areas

highlighted in reflective session discussions. In this sense, the researcher and participants made judgements jointly about what documents and practice areas they wanted to explore and analyse. This was the basis of the reflective discussions with the participants, and the data will be studied in terms of the substantive content, the context of policy and practice, and efficacy.

Review and analysis of the hospital incident management system data and a comparison of the incident categories that aligned with the policies and procedures was undertaken to obtain a background understanding for the researcher prior to interviews and to support reflective processes throughout the interview period in phase one of the research. The data were also available for review by the participants and for discussion in reflective sessions with the researcher.

5.9 The Field Sites

Where phase one only included participants from Hospital B, the phase two study included three hospitals in Queensland, Australia. Hospital A was a 230-bed acute private hospital in a metropolitan area, and the ward identified for study was an acute medical ward. Hospital B was a 180-bed acute private hospital in a regional setting, and the ward identified for study was an acute medical ward. Hospital C was a 160 bed sub-acute private hospital in a metropolitan setting, and the ward identified for the study was a medical ward.

Selection of the wards was undertaken following a review of incident categories across the three hospitals. Patient falls were reported as the highest count per incident category in each of the medical wards across the three hospitals over a recent two-year period. The researcher considered this a commonly measured nurse-sensitive indicator that could provide some consistency in nursing practice exploration and understanding within the research study locations. For this reason, the medical ward in each of the three hospitals was chosen based on analysis of incident data over a two-year period (January 2011 to December 2012) to identify areas of highest incident trend and hence potential areas for research exploration that would be

consistent across the three hospital sites. The researcher also considered that the workflow and patient case mix was similar on the basis of casemix reporting across each of the medical wards, thereby providing a level of consistency in nursing practice experience and flow.

5.10 Participants

The participant sampling approach undertaken in the ethnographic phase of the research was purposive and based on explicit criteria provided by the researcher to the NUMs asked to select participants. First, the sample of participants was sought from a medical ward from each of three acute private hospitals where the researcher was employed and had ethics approval to seek participant involvement in the study. The medical ward environment was deemed appropriate by the researcher on the basis of the prior analysis in phase one regarding the most frequent incident type as patient falls and the consistent casemix that occurred in medical wards. This aimed to seek participants that had some common nursing experience in the type of clinical settings in three hospitals. Two nurse participants were sought from each of the three ward study settings in order to undertake field observations by the researcher followed by reflective sessions. Two participants were determined by the researcher as the sample size from each hospital medical ward on the basis of convenience to complete the observational fieldwork and reflective sessions within a six-week study period agreed with the hospital executive teams. One participant sought was a novice or advanced beginner nurse, and the other participant sought was as a proficient or expert nurse as determined by the ward NUM. This intended to provide the researcher with access to observe nursing practice across the continuum of nursing practice experience and skill sets as described by Benner (1982).

A small and specified number of participants with characteristics for the study determined by the NUM were considered a pragmatic approach when time and financial resources were limited. This approach was supported by Higginbottom (2004) and Gauthier, Melvin, Mylopolous and Abdulla (2018), where key participants were significant in the

generation of ethnographic study samples that provided maximal variation and explored a range of opinions and experience. The participants in phase two of the study were selected by the NUM following the provision of information to the NUM and staff about the research study. The NUM spoke with senior staff in the ward and identified potential nurses for the researcher to buddy with on shifts and to conduct a follow-up reflective session. There was also consideration for nurses that would feel comfortable being buddied for a shift by another nurse who was both a researcher and senior manager, and who would be authentic in their practice and in expressing their views. From those potential participants, the NUMs reviewed the roster, identified the preferred nurses, spoke with them and provided the research information kit for their information and consideration. The researcher then met with the nurses nominated by the NUM to explain the research further and answer any questions, and to complete and sign the consent and participation forms together. Work shifts were negotiated so the nurses were available for buddying and reflection sessions and committed to those dates and times, advising the NUM to ensure that it was reflected in rostering and ward workloads.

5.11 Data Storage and Security

As undertaken in phase one, the same process for data security and storage was explained to participants in phase two, with data stored during and after the study in paper copy locked in a cupboard in the regional executive office and secured network folders for soft copy, accessible only to the researcher. All files were password-protected within the secure network folders and access was limited to the researcher only.

5.12 Fieldwork Schedule

A total of six weeks was allocated per site for each of the three ward locations, working at least two shifts buddied with nurses to observe their practice, and undertaking researcher reflection after each shift and other key moments in practice. Agreement was sought from the GM and DOCS at each of the three hospitals involved in the study. Agreement was also obtained

from the medical ward NUM to discuss research before a negotiated six-week study period, seeking advice on participant selection, methods for initial and ongoing staff/patient engagement, and other relevant issues and context within the ward and hospital. Each of the medical ward NUMs were known to the researcher through professional and organisational association.

The researcher began clinical preparation for the fieldwork by undertaking basic life support refresher and competency, manual handling refresher education and hand hygiene, which were the mandatory areas of competency required for nurses working in a clinical setting at each of the three hospitals. In the quality and safety role, the researcher had already undertaken privacy auditing and other relevant quality and clinical auditing functions that maintained the researcher's competency in these areas. The researcher had current experience in chart auditing and forms review, and pressure injury point prevalence auditing was familiar to the researcher with the medical record utilisation and format, as well as end-of-bed charting and forms. This was perceived by the researcher to be a benefit in being able to establish credibility in an 'insider' nurse role once in the study setting if the participants were accepting of an assumed level of organisational knowledge and practical understanding of these every day nursing practice areas.

5.13 Data Collection

Initial meetings were undertaken with the researcher and the NUM, who both attended staff meetings and clinical handover huddles and provided potential participants with a detailed information research kit that included a covering letter, researcher reflective statement and participant information sheet. A single-page, colour A4-sized poster was prepared with a photo of the researcher and a summary of the impending research study. This poster was provided to NUMs and displayed in key noticeboard areas for staff and patients to view. Researcher presentations on the study were provided at the group level and at local organisational meetings and committees to raise awareness of the research and answer any questions or concerns. This

included Quality Manager meetings, Senior Leadership Team meetings and Group Quality and Safety/Clinical Governance meetings. The general response was consistently positive and enthusiastic, partly because there was explicit support for nursing research. There was limited nursing research occurring in any of the proposed study locations, and the hospital management supported the researcher, who was well known to senior management and many clinical staff.

The researcher sourced fieldwork notebooks that were small enough to fit into the hospital uniform pockets so the researcher could take notes unobtrusively and between moments of care provision, and also easily put the notebook away to assist the participant in the everyday nursing work required for the allocated patient load. This was considered important for the researcher to demonstrate trust and professionalism to the participant, patients and other staff by being present in providing assistance with patient care needs and ensuring patient safety and quality of care.

Fieldnotes were maintained that detailed a chronological account of the participants, their setting and their environmental context prior to, during and after each buddy shift and reflective sessions with the participants. The researcher captured detailed nursing practice discussions and activity as it occurred in a chronological order in a small field notebook. Interruptions and distractions occurring in the ward environment and involving the participants were recorded as they occurred with timings by the researcher. There were also interruptions to the researcher recorded as staff recognised the researcher and stopped to converse and ask questions about operational matters and the research. Reflective practice during fieldwork focused on recording research experiences and methodological issues. Three file types were maintained to assist in the data analysis in phase two, including:

1. A fieldwork file was maintained of observational recordings hand-written in small notebooks in the field and transcribed into text-based format in Microsoft Word before being sent to participants for feedback;

2. An analytic file was maintained of a detailed critical examination of ideas that emerged in relation to questions as the research progressed, as well as reflections and insights that influenced the ongoing direction of the research; and
3. A coding file was maintained that included transcript summaries, coding and themes identified for nursing practice related to policies and procedures.

Data were collated from organisational incident reporting and policy document management systems to identify policies and procedures in place that related to the nursing shifts worked in the hospitals, based on patient care requirements and emerging practice observations. These data were analysed with the participants in relation to identified areas of nursing practice to identify richer detail regarding the relationship to hospital policy and nursing practice. The data were captured in the analytic file, with participants' feedback recorded in memos.

Each fieldnote file in the small hand-written notebook was converted into a Word document and a hard copy document for the participants to review and reflect upon. A secondary document of the transcript was created in Microsoft Word using colour-coding of key themes and policy-related practice areas to highlight to participants for discussion after they had reviewed the initial version without colour-coding. This aimed to explore how nurse participants viewed the buddy shift without the researcher's interpretation, and then to introduce the researcher's perspectives of the shifts for secondary discussion of interpretations. All documentation produced by the researcher relating to the individual buddy shifts were made available to the participants for review and interpretation.

5.14 Data Analysis

A range of data analysis approaches were used to elicit meaning in the data collected in this study. At the micro level, the nurse participants were observed, and meaning was made and transformed through their social and clinical interactions in the setting. The verbal and non-verbal communication and mannerisms of the participants were recorded and reflected upon with

the researcher. The researcher closely observed conversations at the margins of practice to reflect upon in later sessions with the participants, making an assumption that the closer the researcher's and participants' views on nurses' interactions, the more they can understand the everyday practice situations and meaning that they give rise to. Data analysis that focused on the meso, or organisation-wide, and macro contexts was also deemed by the researcher to be important to capture and understand the effect of hospital policy on frontline nurses. Character-driven ethnographic descriptions of data provide a complex portrait of the nurse participants and their views and experiences with hospital policy and nursing practice. The focus on understanding nurses in the everyday context is an important approach to how the data are analysed and reported in this study (Jerolmack & Khan, 2017).

Analytic files maintained by the researcher provided opportunities to continuously test pre-research assumptions by comparing and contrasting assumptions with findings in the research text, which enabled the researcher to address multifaceted interpretations identified from participants, as well as other key contextual roles, literature and personal experiences. This approach provided an opportunity to explore and integrate the observational fieldwork and reflective session processes. Groupings of vignettes or stories relating to interpretation of data were generated from the data.

5.15 Conclusion

Phase two was required in order to fully achieve the aims set out for this study. This phase used an ethnographic approach that consisted of observational fieldwork with six nurses working in medical wards in three acute private hospitals in South East Queensland. The fieldwork consisted of the researcher buddying with frontline nurses to work eight-hour shifts in medical wards and making fieldnotes based on the nursing practice related to hospital policies, followed up with a reflective session between the researcher and the participants. Data on environmental context, practice and experience, and hospital policy processes into practice were

explored through observations, reflexive and reflective processes, and reviews of relevant documentation and databases to develop exemplar vignettes to provide an understanding of the phenomenon.

Chapter Six: Findings and Analysis Phase Two

6.1 Introduction

Phase two of the study aimed to address the need to explore and gain a further understanding of the problem of hospital policy and its relationship with nursing practice. The analysis identified in phase one of the study contributed to the development of the aims for phase two. This chapter outlines phase two of the study, where the junction occurs between 'work as imagined' relating to hospital policy, or what we think nurses do in their practice, and 'work as done' relating to hospital policy. These terms were created by Hollnagel (2014) to describe the incongruency between what we think is occurring and what is actually occurring. In a healthcare context, this reflects what nurses are actually observed to do in their practice. In phase one of the study, the voices of the nurses were privileged in order to explore and understand the phenomenon of policy and nursing practice from nurses' perspective. However, in phase two, the voices and actions of only frontline nurses, albeit with varying levels of experience, were observed relating to hospital policy and their nursing practice, as reflected in the aims of the second study phase.

6.2 Participants

Nurses were identified by their managers and approached as participants in generating the ethnographic study samples in a medical ward in each of the three hospitals included in the study setting. This included a total of six nurse participants across three hospitals, each buddying with the researcher for an eight-hour shift and then meeting with the researcher for a follow-up reflective session. Selecting two nurses from each hospital study setting was considered a pragmatic approach that was appropriate in qualitative research studies where both time and financial resources are limited (Morse, 1987). This approach was also considered suitable for an

ethnographic study in which the sampling is determined by the methodology and topic under investigation rather than the need to create generalisable findings (Higginbottom, 2004).

A summary of the primary participants' demographic information is provided in Table 6.1. Shifts to work were then negotiated so that the participants were available for buddying and reflection sessions and committed to those dates and times, advising the NUM to ensure that it was reflected in rostering and ward workloads.

Table 6.1 Summary of primary participant demographic information

Nurse Participant No.	Setting	Hours Observed in the Field	Hours reflective session	Gender	Years Nursing	Description based on Benner's (1985) model of nursing	Other relevant information
1	Hospital A medical ward	8	8	Female	More than 30 years	Expert nurse	Worked in the medical ward in Hospital A for 25 years, a Clinical Nurse and Team leader in charge of shifts.
2	Hospital A medical ward	8	8	Female	3 years	Advanced beginner nurse	Completed graduate year in Hospital A, worked on medical ward for one year.
3	Hospital B medical ward	8	8	Female	More than 30 years	Expert Nurse	Worked in a range of specialties and different hospitals over past 30 years, worked in medical ward Hospital B for five years, often rostered as Team Leader, and relieves in hospital coordinator shifts occasionally.
4	Hospital B medical ward	8	8	Female	2 years	Advanced beginner nurse	Previously an RN in Nepal for one year before migrating to Australia, completed NMWB requirements for registration, worked in medical ward in Hospital B for two years.
5	Hospital C medical/ oncology ward	8	8	Female	More than 30 years	Proficient nurse	Worked in medical/oncology ward in Hospital C for over 10 years, a Clinical Nurse and Team Leader.
6	Hospital C medical/ oncology ward	8	8	Female	3 years	Competent nurse	RN completed graduate program in Hospital C, worked in medical/ oncology ward for two years, recently completed a post-graduate diploma in oncology nursing.

6.3 Phase Two Research Analysis

The analysis in phase two was undertaken in a three-step process. Initially, the researcher transcribed the fieldnotes generated from each buddying shift, including verbatim quotes from the nurse participants during their shift. The researcher also generated fieldnotes describing the context of the buddying shift. From these fieldnotes and observations, the researcher undertook an initial process of thematic analysis of the data and identified vignettes for each nurse participant that were illustrative of the thematic areas identified.

The second step was to enter into a reflective session with each nurse participant following the buddying shift. This session had two parts, with the initial reflections undertaken between the researcher and nurse participant before they had experienced any of the fieldnotes or observations generated by the researcher. This provided an opportunity to discuss the buddying shift from the nurse participants' independent recollection of the shift. The use of Johns' (1994) reflective model enabled the researcher and participant to understand the participants' recall of the buddying shift, their goals for the shift, consequences or things affecting their decision-making, choices made and lessons learned. Once this had been explored, the nurse participant was then given a copy of the transcript of the fieldnotes from the buddy shift, the initial thematic analysis and vignettes identified from the shift. Having read this additional information, Johns' (1994) reflective model was again used to understand how the participants felt about hospital policy and nursing practice in the vignettes. An illustrative vignette was selected to report on, and exploring what surprised and did not surprise the participants, as well as any lessons learned was recorded.

The third step was then undertaken by the researcher to synthesise the information gained through the buddying shift and reflective session with each nurse participant to undertake final analysis of the data. This was undertaken after all of the reflective sessions were completed.

6.4 Qualitative Context

The researcher set out to explore the context of the research area with frontline nurse participants and asked each of the six nurse participants if they had read all of the hospital policies and procedures related to their nursing practice. A common response of laughter and eye-rolling, followed by many reasons why they did not or could not read all of these policy and procedure documents was reported by each participant. For example, participants stated that they cannot access policies on the intranet, there is no hard copy manual available, they are too busy with patients to look up policies, they are not sure what to look up, and it was easier to ask a clever nurse. This supported the research approach chosen to elicit a further understanding of what nurses think and feel about policy and their nursing practice through immersion in the ward setting at the frontline and to observe what nurses do and say. Opening up analysis in further discussions about what was observed in the follow-up reflective sessions was then possible. If nurses reported that they were not universally reading every hospital policy and procedure, then understanding how nurses at the frontline know what they do and how they use their knowledge to make decisions about nursing practice is an important focus for achieving the aims of this study.

6.5 Observational Fieldwork

A total of six weeks was spent at each hospital site for each of the three ward locations. The researcher worked an eight-hour shift buddied with two nurses at each hospital to observe their practice and undertake researcher reflective sessions after each shift and in other key moments in practice. Buddying shifts are described by ward managers as shifts in which they roster a new or junior nurse with a nurse already working on the ward, and they work together in all aspects of care for the shift. Buddying shifts in every day nursing work emphasises Benner's (1984, 2000) work, which recognises that nurses learn through formal and informal learning relationships. Nurses who have gained experience in patient care deal with many different

instantiations of nursing practice that can be shared with nurses who have not yet experienced such practice (Benner, 2000). Further, buddying shifts provide an opportunity where there is no expectation of clinical competency; rather, the time helps the researcher with exposure to and integration into the actual culture of a ward with the nurse participant (Hellmer & Hruska, 2008). In an operational sense, this provides a safe method for nurses to work on a shift with another nurse who can demonstrate both practical skills and knowledge, and also introduce them to the local workplace culture and norms of practice. Supporting an ethnographic approach within post-modern and constructivist paradigms, the researcher working buddying shifts with nurse participants where the researcher was the inexperienced nurse provided an opportunity for meaningful exposure of the researcher. The researcher was like any other new nurse to the workplace and new to the reality of every day nursing practice in that workplace culture. However, the researcher was not an inexperienced nurse in some areas of practice, with more than 30 years' experience working full time as an RN. The importance of the researcher reflective practice during and following each buddying shift became significant to record and acknowledge.

6.5.1 Process for the Researcher Buddying with the Participants for the Shift

The NUM and nurse participants determined which dates and shifts would be undertaken for buddying and reflective sessions and advised the researcher. This was considered important to the researcher because it gave control to the NUM and nurse participants regarding timing for the research activities that would best fit with their rosters and other ward processes and priorities.

The ward NUM pre-allocated patient loads the day before the buddy shift, provided a copy of the A4 research poster that outlined the research to patients in the allocation area, explained the research study and sought their verbal consent as requested by the researcher. The researcher arrived on the ward 30 minutes before the agreed shift start time to meet with the

NUM and nurse participant to confirm that it was still suitable to buddy with the nurse on the shift and for the patient allocation selected. The researcher wore a hospital uniform and identification badge, with an additional 'nurse researcher' badge worn in a prominent position at chest level to ensure that both staff and patients were aware that the researcher was working on the ward as a nurse researcher for the shift. This was not a requirement of the HREC, but the researcher chose to wear this badge along with the usual identification badge that provided identification as the Director of Clinical Governance. This measure was taken by the researcher to ensure that there was maximum transparency and openness with participants, patients and other staff regarding the dual roles played by the researcher during the research process. It also contributed to the 'insider–outsider' relationship of the researcher with staff and patients during the fieldwork and reflective sessions.

Additional copies of the research information kit and the A4 research poster for staff and patient information were made available by the researcher on the ward for the shifts worked. This was important to inform other staff working on the shifts who had questions or concerns to understand what was occurring and the aims and objectives of the study. The researcher noted the patients that were allocated for the shift and was provided with a patient handover sheet. The sheet had the patient's bed number, name, provisional diagnosis and other key information related to their plan of care. The researcher visited each patient before the shift commenced to introduce herself, provide an A4 poster that outlined the research if they had not already seen one, explain to the patients the research and the observational fieldwork planned for the shift, and confirm that they were aware of the research and in agreement with the researcher buddying with their nurse for the shift. Through verbal consent, the patients agreed that the researcher could buddy with their allocated nurse to observe their nursing practice for the shift as part of the research. All patients agreed to participate in the research process with the nurse under their care. This provided an additional opportunity for observation of nursing practice 'behind closed

doors', which generated interesting reflective conversations between the researcher, nurses and NUMs when reviewing and discussing the fieldnotes afterwards.

As an insider–outsider nurse researcher, having an existing professional and organisational relationship with each NUM and their line managers facilitated the participant selection and consent process as well as the logistics of arranging patient awareness and consent to be completed in a timely manner with minimal issues. This meant that on the day of working the buddy shift with the participant nurse, the shift began as usual with the end-of-bed handover and huddles, because the consent and participation processes had already been dealt with. In nursing huddles, staff congregate at the beginning of a shift to quickly discuss patient concerns, safety issues and general updates before conducting a more detailed bedside nursing handover (Ore, Rosvold, & Helleso, 2019). This was important in enabling the researcher to observe the shift as it usually started, how it operated throughout the day and how it ended. The nursing huddle at the change of shift provided the researcher with an opportunity to explain the research, the buddy shift and answer any questions from the nurse participants and other members of the team. There was a risk that without a well-coordinated approach, this important administrative part of the research process could have created an unfavourable starting point for the study. However, the observational fieldwork flowed seamlessly and generated considerable interest and curiosity from patients and staff alike. In particular, as other staff passed through the ward to perform their daily work, they observed the researcher working with the nurse participants and stopped to ask questions. They were interested in the research study and process, and the identification badge identifying the dual roles of the researcher was a discussion point for some senior staff, who sought further information about the research. This interest and acceptance of the researcher as an 'insider' in the team from other key staff, nurses and doctors was evidenced by comments such as participant one stating,

> "So you know the doctors here? That's good, it helps to know who is who when you are working. Important to have good relationships with the medicos".

Participant two commented,

> "You seem to know a lot of people here and how things work. That could come in handy today if I need to know something".

The ward managers and hospital executive were openly supportive of the research in staff meetings and in welcoming the researcher onto the ward for the buddy shifts. This familiarity with local people and processes contributed to the enthusiasm of the participants in the research process, making it a meaningful and positive experience for the participants and the researcher.

The researcher undertook clinical preparation for the fieldwork by undertaking basic life support refresher and competency, and manual handling refresher education and competency, which were the two mandatory areas of competency required for nurses working in a clinical setting at each of the three hospitals. In the quality and safety role, the researcher had already undertaken hand hygiene auditing, privacy auditing and other relevant safety and quality auditing functions to maintain the researcher's competency in these areas. The researcher's clinical experience at the time of the data collection was limited to chart auditing, forms review and pressure injury point prevalence auditing with the medical record utilisation and format, as well as end-of-bed charting and forms. This was beneficial to the research process and helped the researcher's transition to an 'insider nurse' role in the study setting, as the participants commented, somewhat surprisingly, that the researcher knew the end-of-bed documentation well and had a good level of organisational knowledge.

6.5.2 Reflective Sessions Post-Buddying Shift

A reflective session was held with each participant within 7–14 days after the buddying shift. The description phase provided an opportunity to open up the nurse to what they did and said during their eight-hour shift. As the nurse read the unedited fieldnotes, they showed a range of emotions and commentary, from laughter to shock that the researcher had heard some of the

things they said or observed things that they thought had not been observed or were unaware of some of the observations made—a subconscious unknowing of their practice in some cases.

As a non-regular, 'outsider' member of the ward nursing team, there was potential for greater trust in sharing sensitive information. The researcher's outsider status also challenged her obligation to practice as a nurse, which was more conducive to observing events, and this was a source of reflection by the researcher after each buddying shift. The aims of the research methods were to gain an embodied understanding of the relationship between policy and nursing practice, and hence a need to be systematic and consistent in the fieldwork processes over time. In creating the role of an insider, the appearance of the researcher was considered a powerful association of group identify, as described by Allen (2004), where the nursing uniform and dress standards were inextricably linked to identifying with professional membership, identity, role and status. This reflected the social construction of the identity of the researcher, the subject of the researcher reflective practice during the fieldwork phase of the research. While feeling like an outsider to the local ward culture initially, the researcher blended into the team by assuming common cultural aspects, such as uniform, identification, working approach and participation in nursing activities.

Self-awareness is described as a key skill upon which reflective practice is built, and the observational fieldnotes transcribed by the researcher to the participant provided a method of describing the nurses' practice in particular situations with the researcher's description of what occurred (Burnard, Hebden, & Edwards, 2001). This was a prompt for the nurse participants to consider from their own perspective and memory what had occurred in the clinical scenario or vignette described. Holding the reflective session within 7–14 days of the buddy shift was important in supporting recency of memory of the various scenarios. However, the researcher's description in the fieldnotes or vignettes did not include what the nurse was thinking or feeling at the time of the observation, unless the nurse explicitly stated what they were thinking during the practice situation. This provided a good prompt for the nurses to consider these additional

reflective qualities and, following discussion and reflection, for the researcher to choose an illustrative vignette to include in the study findings.

6.6 Thematic Analysis and Vignettes

Thematic analysis of the transcripts was undertaken, which enabled the researcher and the participants to explore in greater detail vignettes that they agreed were illustrative of the policy–practice relationship. Thematic analysis was a way of identifying, analysing, organising and describing patterns found in a dataset, examining different perspectives of participants and providing a summary of key features in a large dataset (Nowell, Norris, White, & Moules, 2017). Initial identification was made of vignettes that were exemplars of hospital policy and nursing practice, and these were then grouped into themes in order to further examine the similarities and differences in views and experiences. Themes were identified from following the initial analysis of the field data and then the participant reflective sessions to narrow the themes down to five, and participant vignettes were described within these thematic boundaries. The themes were policy variation, policy knowledge, policy mentoring, policy cynicism and policy compliance.

Multiple vignettes were initially presented by the researcher as exemplars for each theme identified from the data; however, these vignettes only reflected a small number of possible vignettes that could be extracted from the observational data. Vignettes are described as text, images or other sources for research participants to respond (Hughes & Huby, 2002). They are used by researchers as recognisable situations to generate discussion and perspectives from different participants in the research process. Each vignette that was chosen as illustrative of the theme has been headlined by a key quote made by the nurse participant that signified the nurses' voices, which were privileged in understanding the context of the themes.

In this research, the reflective sessions held after the buddying shift provided an opportunity to present transcripts of the fieldnotes and initial thematic analysis to the nurse participants in order to undertake reflective discussions with the researcher. Vignettes or clinical

scenarios have been used as a frame of reference for describing field observations where nurses are observed practicing policy, with quotes taken directly from the observational fieldwork and reflective sessions with the participants to illustrate the analysis of the themes identified in the data. Acknowledging that the researcher's perspective only presents part of the story, through the reflective sessions and studying the fieldnotes and initial themes outlined in the vignettes, the limited researcher's perspective is filled out by the perspectives of the participants. Vignettes provide a cost-effective and time-effective approach to analyse research data when participants do not have in-depth knowledge of the research topic but could bring to light nuances and subtleties that only those with insider knowledge may be aware of (Sumrall & West, 1998). The nurses' voices have been used to illustrate the key themes arising from grouping the vignettes in order to further understand the patterns.

An understanding and discussion of the context of situations that occur in complex settings such as healthcare support the vignette approach for exploring context and different participants' perspectives regarding the areas identified in the thematic analysis (Jackson, Harrison, Swinburn, & Lawrence, 2015). The nature of the selection of the vignettes by the researcher and participant from the observational field data can never completely mirror the complexity of a nursing shift generally or for the participant specifically. Text-based vignettes provide limited information based on the researcher's fieldnotes taken during the buddying shift, leaving details to be filled in or left out by the participant. The choice of the vignette by the researcher within thematic areas arguably leads the interpretation and discussion in a certain direction. This point has been explicitly made by the researcher in regard to themes reflecting the social reality boundaries inferred by the researcher. The researcher has used participants' quotations where possible to reflect direct observations that provide selective representations of real-life situations that occurred during the buddying shift. The vignettes provided a useful focus for the discussion of complex inter-related nursing practice activities during reflective sessions with the participants (Hughes & Huby, 2002).

6.7 Findings and Analysis

6.7.1 Vignette Analysis

The participants provided many examples in their nursing practice and in discussion through reflective sessions; however, a small number of vignettes have been selected to provide examples for further explanation of the themes identified in the analysis of phase two of the study. One vignette for each participant has been chosen to provide an illustrative example of the relationship between hospital policy and nursing practice. A summary of the selected vignettes is provided in Table 6.2. A detailed discussion follows.

Table 6.2 Summary of the vignettes

Nurse Participant Number	**Vignette**
One	"The policy is way too hard to follow or make sense of".
Two	"We do what the form says rather than what the policy says".
Three	"It's a good guide".
Four	"I'll come with you if you like".
Five	"Critical thinking is very important as a nurse".
Six	"You know, I don't know where I know everything from".

6.7.2 Nurse Participant One—Vignettes and Reflections

The session began with the participant asked open-ended questions about the buddying shift by the researcher. The participant recalled the buddying shift and reviewed the fieldnotes, confirming that her recollection of the shift was consistent with the fieldnotes and vignettes recorded. The participant had little recall of specific policies relating to her nursing practice during the shift, and stated that she set out as she did each shift to provide safe and appropriate care to her allocated patients. The participant was usually a team leader on shifts; however, this shift she had a patient load and a student nurse (SN) working with her. This meant that she also had a responsibility to provide mentoring and support to the SN, and teaching was a key focus of the shift. The participant reflected that she did not think about policies as such during the shift, but she recalled making reference to information and practices that were probably contained in

policies in her teachings with the SN. As a very experienced nurse, the participant described that her knowledge and skills developed over more than 30 years as a nurse drove her practice rather than reading policy documents. She explained that her skills were the basis or method for dealing with the unpredictability and complexity of each shift she worked. A vignette was identified during the buddying shift with this participant and were the focus of further reflection. The vignette was:

Vignette: "The policy is way too hard to follow or make sense of".

The researcher asked the participant about falls prevention while walking into a patient's room, as there was a falls prevention poster on the wall opposite the patient's bed. The participant stated that they:

> "used nurse specials on patients who fell once or twice".

The researcher asked if they had any alarm mats on the ward to use. The participant said:

> "they did have one once, but they didn't work very well".

The participant said that:

> "the ward gets a greater percentage of dementia patients and infectious disease patients from the surgical ward, so this ward had more high-risk falls patients that any other ward".

The SN working alongside the participant stated that she had:

> "not seen the falls program or red socks before coming to work in this ward",

and she had done some placements in the public hospital in town. The participant explained that:

> "the red socks were issued for patients who were high falls risk".

The researcher asked:

> "From what you said earlier, aren't most of your patient's high risk?"

She replied:

> "Yes, we do usually just give them all red socks because most of them are high falls risk, and you don't miss anyone then".

The participant signed care plans and assessment forms for falls prevention, which she described as easy to follow. However, she described the post-falls policy as:

> "way too hard follow or make sense of",

but she said:

> "the manager was working on improving it because so many nurses had complained about it".

Reflection

The participant reflected on the fieldnote-generated vignette that was presented and confirmed its accuracy. She then reviewed the Falls Policy and the Post-Falls Management Procedure that had been downloaded and printed. The participant recognised that much of what was documented in the policy was consistent with her practice, and while she had not read the policy, she had read the procedure and reiterated that it did not make sense to most nurses. This was because it did not align with what actually occurred in every day practice, and it was inconsistent with the forms and processes that actually occurred in a ward setting. With so many junior nurses and student nurses working on the ward, it was generally considered easier to put all patients in a pair of red socks to reduce falls risk, which she stated was consistent with the policy requirements for high falls risk patients, which was the majority of the ward patients. At worst, it was a more cautious or additional control for patients assessed as medium to low risk of falling. The participant further explained that she did not necessarily encourage student or junior

nurses to read the policies or procedures because they could cause confusion. Learning on the job from more experienced nurses was considered more relevant and appropriate.

6.7.3 Nurse Participant Two—Vignettes and Reflections

The session began with the participant asked open-ended questions about the buddying shift by the researcher. The participant recalled that she did not read policies except for when she first started working on the word as an orientation and induction exercise, and she stated that she:

> "learnt on the job with other nurses".

She said that she did not recall anything extraordinary during the shift other than finding a pressure injury on a patient and asking the researcher for assistance in staging it and reporting it into the RiskMan incident reporting system, as she felt unsure about how to stage it and report it into Riskman. She explained that the shift:

> "ran as usual, with good patient care provided by her",

which is what she:

> "always tried to do",

and there were:

> "no unexpected occurrences with her patients".

The nurse explained that she was grateful that the researcher was there on the shift to talk through areas of practice and ask questions about what was done elsewhere. The nurse expressed her desire to gain further experience in other areas of nursing and midwifery practice, and the medical ward was a good grounding for that further study. The nurse described that she felt that the NUM and educator were watching her practice closely based on what they saw at handover times, when she was tired and could not recall some aspects of care. She felt that they viewed this as reflective of her not being a good nurse or not understanding safe nursing practice.

However, she felt that she practiced safely, but as a single mother with three young children at home, she was often tired when she came to work and felt that was the cause of her lapses in clinical handover at times. The participant reflected on the number of other nurses on the ward who approached her during the buddying shift and on many other shifts to ask her practice questions or for help with practice. The participant and researcher read the vignette about the patient falls policy and discussed the nurse participant's comment about the lack of time to read new policies or changes to policies. She said that she:

> "was surprised that the researcher had recorded her words verbatim",

and reflected on what she had said from the transcript of text. She laughed at how honest she had been, but did not think that the researcher would record that level of detail. The vignettes were discussed with the participant during the buddying shift, with one illustrative vignette selected:

> **Vignette:** "We do what the form says rather than what the policy says".

In discussion with nurses about the falls policy, the nurse said:

> "There are signs up everywhere saying that there is a policy around, so you can see here is a new policy, but you don't have time to get to read it, and sometimes it doesn't make sense anyway. Take the falls risk form and policy. We are told about it and there are changes, but the [Falls Risk Assessment Tool] FRAT form says do the risk assessment daily, so we do what the form says rather than what the policy says. But then there are what other nurses tell you to do, and the back of the strategies form gets missed all the time. Red socks are meant to be issued for patients who are high falls risk, but we usually just give them to all patients because most of them are high falls risk and it makes sense to give them to all patients rather than miss something".

Reflection

The participant reflected on the vignette presented by the researcher and confirmed its accuracy. The participant practiced variation from policy in her every day work, but it was not based on an explicit knowledge of the policy details that led her to make a conscious decision not to follow the policy. Rather, she stated that it was:

"based on a desire to provide safe care to her patients"

and to:

"find practical ways to get through her shift",

by relying heavily on her nursing peers to interact with and share experiences, perspectives and knowledge. The participant expressed the desire to do the right thing in providing safe care to her patients, and her reflection on policies not making sense was more based on what other nurses told her rather than her own understanding of and judgement about the efficacy of the policy documents. This was apparent because she could not recall reading the source documents, and the researcher's investigation into the document management system audit trail revealed that the nurse had never accessed the policy to read online. With no hard copy policy documents available on the ward, the nurse participant's frame of reference was her nursing colleagues, her own experience and the end-of-bed nursing documentation or signage on the ward walls.

The participant reiterated that she:

"did not actually know what the falls policy said",

So, she and most other nurses:

"just followed what the bedside form said to do",

as that was the most relevant and practical thing she could do. She explained that another nurse had told her that:

> "The falls policy was different to the falls form, but to just follow the form to be safe, as that was what the manager would check to see if you had provided cares that you were supposed to do".

The participant related that she understood that the aims of the falls policy, forms and signs around the ward were to prevent patient falls and to keep patients safe from injury. However, she explained that when you were busy:

> "It was easier to put red socks on every patient to keep them safe, even though it probably wasn't what the policy stated to do, but it was probably still safe",

and she was unlikely to get into trouble for putting red socks on a patient. If she did not put them on a patient and then the patient fell, then she could be in trouble with the manager:

> "This practice translated into safe practice," she surmised.

Being able to access the policy was difficult because of a lack of time with the daily nursing workload, minimal computer access and difficultly in knowing where to look. Just following the form and putting all patients in red socks seemed like the most obvious and safest thing to do, and she asked:

> "How could that be wrong?"

The participant described her reliance on what she had been shown by the other nurses on the ward when she first started there. Further, no one on the ward had ever encouraged her to take time out to read policies and interpret how they related to their everyday practice. During the reflective session, the participant, with the researcher's guidance, accessed the patient falls policy on the computer and read the policy. She stated that she was surprised at the detail in the policy, and much of it was familiar to her and reflected her every day practice. However, she also reflected on the assumptions that she had made in this area of practice, and wondered aloud

about how many other areas of practice she had taken for granted, asked another nurse for advice and trusted whatever they had told her.

6.7.4 Nurse Participant Three—Vignettes and Reflections

The session began with the participant asked open-ended questions about the buddying shift by the researcher. The participant recalled her experience with policy and nursing practice during the shift by recounting a number of policy non-adherence practices that she identified during end-of-bed handover with the night staff. She reflected that she was usually aware of this as a senior nurse to use handover as a learning and teaching space for herself and other nurses, but she felt she was more aware than usual during the buddying shift because of the presence of the researcher. However, she recalled issues around medication storage and management of central lines being identified by her during morning handover, and she expressed a desire to use such opportunities to ensure safe care and educate less experienced nurses in key areas of nursing practice. The participant was a senior nurse on the ward, often working as a team leader. In that capacity, she explained that she:

> "Felt responsible to be aware of policies, including their development and revision, so that she could share her knowledge with other less experienced nurses".

Ultimately, the participant explained that she aimed to:

> "ensure safe and appropriate nursing care was provided to all patients in the ward".

Thus, even if she noticed care or practice issues regarding patients that she was not allocated to provide direct care for, she would intervene if she was concerned about the care or safety of the patient or staff. As a result of this ethical practice approach, the participant explained that she:

> "considered herself approachable"

as she had a:

> "teaching rather than punitive focus on nursing practice".

This was evidenced with the many interruptions in the participant's care during the buddying shift, as other nurses sought her advice and supervision throughout the shift, even though she was not the team leader allocated on that shift. The participant explained that she had:

> "reflected on the buddying shift since completing it"

with the researcher. She expressed that participating in the reflective session off the ward was valuable to her as a:

> "Reminder of the need to take time out to critically think about your nursing practice with another experienced nursing colleague who could share in the experience of that practice space".

The vignette discussed with the participant during the buddying shift related to a patient transfer from the Recovery Room to the ward:

Vignette: "It's a good guide".

The nurse went to the Recovery Room to escort her patient back to the ward after her operation. A Recovery Room nurse gives the nurse a bedside handover. Another hospital's policy of post-operative orders was printed out on the bedside table, with areas highlighted for minor post-operative observations. The nurse asked the Recovery Nurse:

> "She had Propofol, so doesn't that mean she's had a General Anaesthetic?"

The Recovery nurse said:

> "Some say yes, some say no. It wears off pretty quickly, so I would probably only do half hourly obs for an hour and then hourly for two hours, but I'm not sure what the hospital wants you to do, but have a look at this other hospital policy. It's a good guide".

The Recovery Nurse pointed to the printed policy with highlighted sections on the bedside table. The nurse participant returned to the ward with the patient, settled her into her bed and told the patient:

> "I'm just going to check your BP, how are you feeling?"

The patient said that she:

> "felt heavenly, as though something had finally been done".

The nurse participant took the patient's blood pressure, heart rate, respiratory rate, oxygen saturations and temperature and recorded the results on the track and trigger chart. The nurse participant noted the oxygen saturation measurements were 94%, and she asked the patient to take some deep breaths and to roll so that she could look at the surgical site. The nurse participant noticed a small dressing on her back that appeared clean and dry. She settled the patient sitting up and said that she would go and make her a cup of tea. As we left the room, the nurse participant explained that the patient was given Propofol in her anaesthetic and she has a history of bronchitis, so she asked her to breathe up to bring her oxygen saturation levels up a little, stating:

> "She's still a bit groggy you know, so I'm going to do more observations than the Recovery nurses said are necessary to make sure she is all right".

Upon further discussion with the nurse, and after searching the intranet, we noted that there was no approved hospital policy in place for post-operative observations; however, there was a draft in a folder in the office, with lots of writing all over it, so nurses had to do what they believed was safe for the patient.

Reflection

The participant reflected on the vignette selected with the researcher and confirmed its accuracy. The vignette demonstrated a number of relevant considerations for the nurse's policy practice. The participant explained that she had used her own critical thinking skills and experience in assessing the patient's condition, and she viewed the Recovery nurse's description of another hospital's observation policy as:

> "a good guide"

The participant undertook her own patient assessment on returning to the ward and explained her reasoning for undertaking more frequent observations, while also looking for a local hospital policy. On finding the draft policy in the NUM's policy folder, the nurse participant cross-checked the draft policy with her own assessment and confirmed that she would continue to complete more frequent observations until she assessed that the patient was stable. She further explained that she handed over to other nurses about her perspective on safe practice relating to observations, with a mentoring and teaching focus for junior nurses as the basis for safe nursing practice.

6.7.5 Nurse Participant Four—Vignettes and Reflections

The session began with the participant asked open-ended questions about the buddying shift by the researcher. The participant reflected that when a nurse says they are busy, the nurse generally does not see the complexity of the things they do. Reading the fieldnote transcript highlighted that complexity and explained:

> "That is not covered in your curriculum at university, you have to learn how to deal with it on the job".

The participant described the buddying shift as:

> "a normal day at work with no surprises".

She described policy as:

> "embedded in many of the practice that nurses did to ensure safety for patients and staff".

What she found most surprising was the number and variety of interruptions to her day by a range of different staff and patients. The participant reflected that it was:

> "probably easier and faster for less experienced nurses to ask someone who will know"

and that it was:

> "often difficult to locate a specific policy unless you were already very familiar with it".

This made it challenging for new nurses, particularly when all ward computers were in use and time was limited. The participant explained that she:

> "often only knew about policy changes or new policies as she came across information in her every day practice".

For example, she explained how:

> "The policy on transferring patient to the Operating Theatre had changed over time. Patients get admitted direct to the Operating Theatre now, and the ward doctors have to admit them and write up their medications".

The participant learned about this change two weeks earlier when there were two doctors waiting on the ward to admit the afternoon Theatre cases and the patients had not arrived on the ward. The participant phoned the Operating Theatre and were told that the patients were already there being admitted by another doctor. There was no written policy or procedure to reflect this change in practice, and the participant assessed that it was a good change but highlighted that:

> "not everything that nurse's practice is committed to a documented policy or procedure".

There is a need for nurses to think critically about their practice in their everyday work, as not everything is recorded in hard copy. This can be challenging for new nurses, and they have a folder for Operating Theatre patients on the ward to assist new nurses to understand how to care for these patients. However, practice and processes change all the time, and the policy documents are not always up to date with the changes that have occurred. The participant further explained that there:

> "Was always some different interpretation on policy by different nurses who had different types of experience with similar scenarios".

She further described policy as:

> "like the spinal cord, insofar as you do not notice it until it is broken".

If nurses have personal accountability for their nursing practice, then it is important to practice communication, trust and information exchange safely and appropriately at all times. In this way, less experienced nurses are encouraged to ask more experienced nurses on the ward for assistance in areas that they are unfamiliar with or need help in problem-solving. The participant cautioned this approach, describing that in her experience:

> "Nurses would go to someone who they were comfortable with, who would not laugh at them or intimidate them".

However, sometimes that is not the most knowledgeable nurse to assist them in their practice, and this may contribute to poor safety or poor nursing practice. The illustrative vignette that was discussed related to the participant mentoring a junior nurse:

Vignette: "I will come with you if you like".

A graduate nurse asked the participant if she knew whether her patient had the IV line changed on her central line, as she missed that part of handover. The participant said she did not know, but told the graduate nurse:

> "If you are going to change the line you should change the bag as well, I will come with you if you like".

The patient's IV pump was alarming, and the nurse participant went into the patient's room with the graduate nurse and said to the patient:

> "You're beeping, I just need to get a flush and then I will help your nurse change the line and bag and that should stop it beeping".

The participant then assisted the graduate nurse and advised her to write it up in the patient's progress notes and care plan.

Reflection

The participant reflected on the vignette with the researcher and confirmed its accuracy. The participant described that her approach to her every day work was to:

> "assist, mentor and develop graduate and new nurses in providing safe patient care".

There were a number of important infection prevention practices that she knew were not obvious to graduate nurses, and when she saw opportunities to provide guidance to support the development of other nurses, she offered to provide assistance. The participant had knowledge of the policy requirements for line changes and used handover as an opportunity to both learn and teach. She also took the opportunity to include the patient in the teaching space, being explicit about the need to share knowledge with other nurses. She described how she tried to:

> "ensure that the patient felt safe and the supervision of less experience nurses was taken seriously by more experienced nurses".

6.7.6 Nurse Participant Five—Vignettes and Reflections

The session began with the participant asked open-ended questions about the buddying shift by the researcher. The participant recalled the buddying shift as an ordinary patient care shift; however, she worked as a team leader on many shifts where she did not take a patient care load. She had worked in the ward for many years as a senior nurse and explained that she:

> "relied on the team huddles and education sessions to keep up to date with policies and procedures".

She stated that she:

> "did not routinely go looking for policy documents, and generally did not have time to look them up".

Rather, she relied on her experience and longevity of working on the same ward to know that she has dealt with many clinical scenarios that cover most of the relevant policies and procedures. The participant emphasised that the critically thinking nurse is important in providing safe and effective care in every day nursing work, and generally conferred that policies and procedures only add guidance to those that do not have the skills required for the nursing practice area concerned. In a busy medical ward, she explained that:

> "Patients can deteriorate quickly, and nurses needed to be able to assess and prioritise their work and respond quickly in a rapidly changing environment".

Where she could, she aimed to share her knowledge and mentor less experienced nurses to understand their practice and to be able to respond to changes in patient care as necessary. Sometimes this meant:

> "searching for a policy, but more often meant finding another more experienced nurse to assist or advice you".

The vignette used as illustrative for reflection related to Central Venous Line and clinical judgement:

Vignette: "Critical thinking is very important as a nurse".
The participant was reviewing a patient's chart and explained that he had a Central Venous Line in situ and it was:

> "Meant to have the IV solution changed every Monday, Wednesday and Friday and the IV cannula and line change is meant to occur every three days, and subcutaneous lines are changed weekly in this hospital but in the community, they can stay in situ for up to a week unless they are red".

The researcher asked the participant how she knew what to do, and she explained that it was:

> "Originally developed from a policy, but I can't say that I have ever needed to look up the policy. If I'm putting in a nasogastric tube, I would look up the policy because I don't do that very often, but with procedures you can't always stick to it all the time, like the PICC policy cleaning it three times in a week".

She explained:

> "Sometimes the policy just doesn't work and you need to use your clinical judgement or common sense. But some nurses are crap and just do tasks, and don't think when they do things, so the policy sets some parameters for them, but I think that critical thinking is very important as a nurse".

She said:

> "There is usually not enough time to do all of the paperwork that you are meant to do and I think that person-centred care means focusing on what the patient needs first and paperwork second".

Reflection

The participant reflected on the vignette with the researcher and confirmed its accuracy. The participant privileged the role of critical thinking in every nurse's daily practice in order to effectively and safely manage the complexity of working in an acute care medical ward. Associated with critical thinking was the use of clinical judgement and common sense for patient assessment and management. In this sense, the nurse participant described that the challenges of nurses are:

> "task-oriented and follow pathways and policies without thinking about what they are doing".

She challenged the notion that:

> "one policy or procedure document could be applied to every single different patient scenario",

describing this as:

> "not making any sense".

Policy was viewed by this nurse participant as a guide to practice, which a nurse could then use in combination with experience and knowledge to provide safe and appropriate patient care. This further supported her notion of mentoring other less experienced nurses and encouraging them to think about and reflect on their practice and that of others in team huddles, nursing handover and team meetings. Having worked in other public and private hospitals, the participant had experienced different nursing practices for similar treatments and patient scenarios. She described an understanding of the evidence base required to define and produce policy and procedure documents, but viewed this as:

> "guidance that needed to be overlaid with critical thinking and clinical judgement in order to achieve the best outcome for the patient".

6.7.7 Nurse Participant Six—Vignettes and Reflections

The session began with the participant asked open-ended questions about the buddying shift by the researcher. The participant was approximately three years post-registration and had completed post-graduate studies in oncology nursing. She recalled the buddying shift as a fairly normal shift in the ward. There was one patient who became neutropenic and she had to divert her attention to caring for him and obtaining a medical review. The participant reported a degree of cynicism in paperwork and policy, reinforcing that she would always put patient care and patient safety above paperwork and policy. She described her working day as patient-focused, and she reinforced the importance of including her patients in choices and decision-making about their care as much as possible. However, while she did not initially view the role she played in her every day nursing work as sharing knowledge or mentoring other nurses, following the review of the fieldnotes and the vignettes, she was able to revisit this aspect of her nursing practice. The vignette that was chosen as illustrative of her every day practice related to her knowledge of hospital policies and practice:

Vignette: "You know, I don't know where I know everything from".

The participant turned to the researcher and said:

> "you know, I don't know where I know everything from",

and she said she did not read a lot of signs. Even though there were many up on the walls, she said that she was more of a hands-on learner and could not stand having to sit through long meetings. The participant said:

> "When there is a new policy you hear about it in the huddle at the beginning of handover and via email, and the educator is great and goes through a weekly education plan and

writes lists for people to do education, so you do not really have to remember that yourself, because they chase you up, and you can do what you come here to do, look after patients".

Reflection

The participant reflected on the vignette with the researcher and confirmed its accuracy. She reinforced that she relied on:

"the ward processes and educator to know about policy changes",

but they were not something that she proactively sought out. The participant acknowledged that she had a good knowledge of nursing practice related to the medical ward, but she reiterated that:

"she was often surprised at how much she knew about the practices on the ward".

She stated that she:

"seemed to have well developed critical thinking and clinical judgement skills that she could apply in her nursing practice daily",

surmising that this was a result of post-graduate education and a commitment to lifelong learning.

6.8 Thematic Analysis

The thematic analysis approach was described in Chapter 4, which provided a structure to make sense of the data extracted from the interviews in phase one. In phase two, thematic analysis was used again to provide a method for appropriately describing, analysing and reporting themes that emerged from the field. In this sense, a theme was again considered an important concept or attribute that was identified by the researcher in the data and represented a pattern of meaning that was relational to the research aims. An inductive analytic approach was used to explore the themes linked to the data, which enabled the data to progress from

descriptions into themes for vignettes to support the interpretation and understanding of the broader meaning of the data. This approach also enabled the researcher to consider each theme individually and in relation to the other themes to support the transition to the final five thematic areas prevalent within the vignette analysis: variation, knowledge, mentoring, cynicism and compliance.

6.9 Policy Variation

This theme arose from a number of vignettes where participants across the three hospitals demonstrated that they varied their nursing practice from what the relevant policy or procedure stated. They did not view their scenario of policy variation as non-adherence or non-compliance with the policy, but rather a pragmatic approach to nursing practice that was appropriate to the care required and provided to their patients. The vignettes that were considered exemplars to further explain this theme have added to the understanding of complexity in nursing practice within a hospital setting—particularly where participants have varying levels of nursing experience. Four of the participants (participant one, two, three and five) discussed vignettes that further explained how they viewed policy variation as significant to effective and responsive nursing practice rather than a non-compliance issue to be managed.

6.10 Policy Knowledge

This theme arose from vignettes generated from five of the participants (one, two, three, five and six) and reflected the significant role that knowledge plays in the understanding of policy and nursing practice. This reflects the type of knowledge that nurses use in their daily practice, where and how they acquire the knowledge they use in their practice, and how they share knowledge to enhance their practice. There was an overlap with policy mentoring, where nurses with knowledge of policy and practice were well placed to undertake supervisory and mentoring roles and relationships with other nurses in their everyday work.

6.11 Policy Mentoring

This theme arose from vignettes generated from three of the participants (three, five and six) and provided a practical process for nurses sharing knowledge about policy and practice. This was largely in the context of nurses working in complex healthcare settings with teams reflecting novice to expert nurses that find formal and informal ways of sharing knowledge and ensuring safe nursing practice. This is challenging in the fiscally constrained environment of healthcare, where time for education and formal training is limited and nurses have found informal ways of mentoring and sharing experiences to improve nursing practice and care.

6.12 Policy Cynicism

This theme arose from vignettes generated from two of the participants (two and six) who expressed a level of cynicism about how policy related to practice. They reflected the views of their nursing peers in feeling challenged by the administrative and managerial aspects of the policy processes. These participants viewed policy processes as a distraction from their focus on patient care and as a resource-intensive method of dealing with nursing practice that is removed from direct patient involvement and day-to-day care. The reality of not knowing every policy and procedure related to the delivery of nursing practice, and the reality that many aspects of nursing practice have not been reduced to documented policies and procedures, were obvious challenges to every day nursing practice raised by these participants.

6.13 Policy Compliance

This theme arose from vignettes from one participant (four) who expressed concern about the way in which policy had been perceived by nurses as being driven from a compliance and managerial perspective. This was reflected in the incident reporting processes across the hospitals, as well as the incident investigation processes where policy non-compliance was identified as a common contributing factor to adverse clinical events and overlapped with the thematic findings and analysis around policy violation.

6.14 Analysis of One Nurse Participant Eight-Hour Shift and Comparison of Policies and Procedures Related to Nursing Work

Following the process of undertaking vignette analysis, the researcher conducted an interesting one-off analysis of the total number of policies and procedures under which nurse participants practice during an eight-hour shift. The researcher reviewed the observation fieldnotes for the buddying shift worked with nurse participant number one. If they were to read and have an awareness of every local, regional or national policy and procedure relevant to their shift, they would be required to practice under a total of 108 policy and procedure documents published by the organisation (see Table 6.3).

Table 6.3 Summary of policy and procedure documents relevant to nurse participant one working an eight-hour shift.

Type of Policy/Procedure Content		Clinical	HR/WHS	Financial/Sustainability	Mission
Level of Policy/ Procedure Development	National	2	4	1	1
	Regional/ State	11	39	10	3
	Local Hospital	25	8	4	0
Total Policy and Procedure Documents Published		38	51	15	4

The number of documents a nurse would be required to know or be aware of would vary in the clinical category from shift to shift depending on the patient care requirements for each shift. Thus, the problem with policy is the pretence that we can know everything there is to know to work a nursing shift, even if it means looking up a policy or procedure document on the computer. However, it is important to acknowledge that nurses are constantly working in a world of practice with uncertainty, and understanding what occurs in practice is an important contribution to ensuring safe and appropriate nursing practice. Nurses seem to operate in a space that is tacitly compliant, and the practice of compliance is not as binary as it initially appears. Many practices in this nurse's shifts are not guided by policy or procedures, for example, nursing

assessment and management of a patient with urinary retention with an indwelling catheter in situ. A policy could not have guided this nurse's practice, as a relevant policy or procedure does not exist to guide every patient scenario for nurse participant number one. Further, upon reviewing the document management system, the researcher ascertained that in the previous three years of database records, nurse participant number one had not accessed any of the policies and procedures online that she would be expected to have read and been aware of.

6.14.1 Achievement of Aims (Phase Two)

Phase two of the study set out to achieve two aims:

1. Develop an understanding of the relationship between hospital policy and nursing practice by observing how nurses with a range of experience practice in an everyday work setting; and
2. Describe the relationship between hospital policy and nursing practice that promotes discernment and discussion towards improving patient safety and ensuring high quality of care.

These aims have been achieved through the research methods and analysis undertaken to understand the experience of frontline nurses working in their everyday practice settings and to provide a description of their relationship with hospital policy and nursing practice. The next chapter provides the discussion towards improving patient safety and ensuring high quality of care in this paradigm.

6.15 Conclusion

Fieldwork in ethnography is important to enable the researcher to encounter the context of the culture and be able to write about it. The researcher entered three hospital medical ward settings and got to know the people involved at the site by buddying with the participants in their daily routines, developing ongoing relationships with the nurses in the wards and conducting

observations. The researcher found that immersion in ethnographic research is about being with other people, learning how they respond to situations and organise themselves, and learning what is meaningful to them. This enabled the researcher to see things from their perspective. Being able to safely provide basic care and assessment, working alongside the participants, sharing handover, meal breaks and crises/problem-solving provided a greater opportunity for acceptance and inclusion in the workplace.

The researcher's fieldnotes contained descriptions of what had been seen and experienced, along with perceptions and interpretations of events. They contained a passive account of the facts of events and the active processes of sense-making of the researcher's feelings and interpretations of what had been seen and experienced by the researcher. This guided the researcher to further inquiry, questioning and discussion with the participants, which opened up the data for a more in-depth understanding of the group. This immersion and sense of place that was assumed and strengthened enabled the researcher to inscribe detailed context-sensitive and locally informed field notes.

The researcher undertook observations, in-depth interviews and a review of the documentation as a way of using multiple sources of information to better understand the situations observed. Results of these methods helped to examine the validity of the data gathered through each method by triangulating the information. The findings, discussion and conclusions of this phase will contribute to the empirical knowledge about the relationship between hospital policy and nursing practice in a private healthcare setting. As an ethnographer, the researcher sought to learn from the participants' point of view rather than study them as objects. This was achieved in support of the aims of phase two of the study. The researcher sought to learn what the participants knew and how they came to know it, and to understand their experience, walk in their shoes and feel things as they felt them. This was intended to assist the researcher to explain policy and how it related to nursing practice as the participants had explained it. The understanding gained from both phases of the study of the relationship between hospital policy

and nursing practice, from a nurse's perspective, will be discussed in the next chapter to synthesise what has been learned and to consider practical implications for nursing practice.

Chapter Seven: Discussion

7.1 Introduction

This chapter provides the synthesis of the study and presents a discussion of the findings. The results outlined in the previous two chapters in regard to the practical implications for exploring and understanding the relationship between policy and nursing practice and the strengths and limitations of the research approach and methods are discussed. This chapter consolidates the previous chapters regarding the relationship between hospital policy and nursing practice and concludes with a summary of the researcher's reflections and recommendations. There is no explicit section included on a comparison of the literature reviewed; however, this is substantially demonstrated throughout the discussion to demonstrate where the study has considered and moved beyond the literature. This study began with the contention that the relationship between hospital policy and nursing practice is contested, and this was elaborated upon and tested in the subsequent chapters.

7.2 Discussion

7.2.1 Post-Modernism and Constructivist Paradigms

The theoretical basis for this thesis was presented as a constructivist paradigm that proposed a number of assumptions on the phenomenon being studied. Knowledge from existing mental models was used based on previous learning, assimilation of new information was challenging, critical thinking was more meaningful than memorising information to drive change, and reflective practices provided meaningful learning to support new and existing knowledge (Brandon & All, 2010). This discussion sets out to provide a synthesis of these assumptions with the findings and analysis in order to provide evidence of the achievement of the study aims, supporting the adequacy of this paradigmatic approach to the study.

A key premise of this study was in the understanding that healthcare is complex; however, in terms of policy, it is treated as if it is simplistic and linear, with problem-solving always sequential and being resolved with simple repeatable methods. Metrics are expected to be used to measure processes and outcomes, focusing on controlling the procedural and manageable aspects of care. This perspective places an emphasis on nurses being circumscribed to behave in certain predictable ways in a controlled and predictable system (Iedema et al., 2013). However, the process of learning and discovery challenged the views of the researcher and the participants involved in this study. This study challenged participants to remove the rhetorical boundaries that they or others place around them as nurses, and to be their authentic professional nursing selves. Participants were asked not to deny the disturbances they felt or the complexity and dynamism that confronted them in their everyday work, but to talk about how they felt or what they thought and how that influenced what they did. This reflected how these nurses viewed the relationship between hospital policy and nursing practice. Trust and open communication were built by working alongside these nurses in their everyday work and making conversation and learning as colleagues.

Trust was built quickly with the participants through both symbolic and practical approaches. Written information was provided to participants before meeting them, and the researcher wore the usual hospital nursing uniform when working, provided information to patients and staff at the commencement of the shift and answered questions throughout the shift. The researcher was both an insider and outsider in this context, but was quickly accepted as an insider into the local culture as a result of legitimisation by the ward manager and/or quality manager, other nurses and doctors on the ward. The familiarity with which the researcher was introduced into the research setting provided opportunities for a deeper conversation and understanding of the role of clinical communication and ways of knowing in promoting safe practice.

There was a prevailing assumption that policies, procedures, protocols and guidelines help nurses to deal with the complexity they face every day and to make decisions in their practice. However, understanding the context in which they practice is important in this process. This scenario was described by Iedema et al. (2013, p. 5) where the care of specific patients remained contextual to the implementation of:

"rules and resources devised by experts elsewhere".

This principle was also described by Øvretveit (2011), who stated that if we understand local contexts and their needs, we can improve the possibility that experts' rules and resources will be appropriately implemented. Generalised rules take the practical complexities of every day practice into account (Berg & Timmermans, 2000). The novice or beginner nurses in this study tended to trust the policies as correct and best practice; however, the more experienced nurses were less trusting and more cynical about the correctness and application of the policies.

Concerns were raised that generalisation in rules may also be simplifications and may not actually support nurses to make connections between rules and context because every day practice is complex rather than linear, sequential and repeatable (Iedema et al., 2013). Iedema et al (2013) argued that the practical choices and decision-making facing frontline nurses cannot be affected by any number of protocols or guidelines. This implies that there must be some other phenomenon at play to explain how we get things so right so often or unbelievably wrong at other times. But healthcare does not operate in a simple linear or sequential manner; rather, it is viewed as complex and as a world of many shades and variables that require different styles of thinking and knowing to navigate safely. The practical knowledge required for clinicians to apply rules to situations with uncertainty and complexity and to determine whether nurses can apply rules in in-situ practice was described (Nicolini, Gherardi, & Yannow, 2016). There are some differences between novice and experienced clinicians in dealing with complexity in practice (Jorm, 2012; Messman, 2008). This is where novice or beginner nurses encounter

unpredictables, and they may require experience beyond their capability to resolve the situation. Senior or experienced nurses can solve problems and take calculated risks as bricoleurs to resolve situations. In this study, nursing workarounds were evidenced in every day nursing work. For example, the RN and SN reviewed an alarming IV pump, and the RN explained to the SN that she only set the pumps up for two hours and then reviewed them to make herself come back to review the patient at a minimum of every two hours because it alarms.

7.3 Complexity

Complexity plays out in healthcare not just in terms of increasing technical complexity or patient illness and disease complexity, but in the way nurses and healthcare organisations are structured and how they respond to clinical matters (Iedema et al., 2013). A broom was presented as a metaphor by Lillrank and Liukko (2004) to describe the complexity of quality and safety where work is standard, including policies and procedures, routine and non-routine. The broom handle related to quality and compliance systems and standardisation of practices, the brushing part of the broom reflected levels of uncertainty and non-routine practices subject to failure, and the middle part of the broom reflected routine practices with a lot of certainty. They described the untoward happenings during standard complexity seen as deviation from practice. This is how hospital policy and procedure adherence in system reviews of adverse events can be viewed, with high levels of uncertainty reflecting non-routine practices and failures. They describe a routine level as more abstract and allowing discretion with decision-making, where errors may still occur, and the non-routine level of complexity with a lot of uncertainty, where policies and procedures may apply. This representation of safety emphasises that safety issues use different guides with different levels of complexity. Non-routine practices require creativity, and Lillrank and Liukko (2004) argued that emphasising some clinical practice requires more experience and critical thinking than simply following a policy or procedure. This is where risk assessments and trade-offs occur. For example, a participant chose not to wear gloves when cannulating a patient for intravenous cannula access, as she stated that she had better success the

first time if she washed her hands but did not use gloves. This was an experienced RN who understood the risks associated with not following standard precautions and the potential for needle stick injuries. The participant weighed these risks—a form of dynamic risk assessment—against her desire to minimise harm and inconvenience to the patient with the aim of avoiding multiple attempts at cannulation. The nurse chose to privilege the safety and experience of the patient over her own safety, as she understood her level of skill and competence and gauged her chances of cannulating the first time without gloves. There are clinical ethical dilemmas inherent within this scenario, as well as workplace safety/industrial relations considerations.

Nurses work together to negotiate uncertainties and complexities; through this behaviour, they continue to learn and develop in their practical knowing in an ad hoc manner. To maximise the power of these processes, it is important to encourage nurses to become aware of and understand shared knowledge about complexity and uncertainty in their everyday work (Iedema et al., 2013). This kind of practical knowledge is represented by the safety stories shared by the nurse participants in this study.

These scenarios observed during the fieldwork reflected the self-organising practice of nurses to put safe nursing practices in place, regardless of what policy or procedure does or does not require of them. The importance of stopping to see and listen was emphasised as an important part of reflective practice in this study. Examples of reflective practice were implicit throughout all of the vignettes; however, for the most part, they were subconscious reflective experiences and without labels applied by the participants as such. It was simply something that the participants practiced in their everyday work, and until the research process labelled the processes and thought patterns as reflective, they generally had not privileged them in such a way. They recalled reflective practice as something one does as an SN with a facilitator at the end of a day of ‘prac’ or a student reflective journal kept during placement. That is, it is a dedicated space of time allocated or a document to complete rather than a process that is

inherently woven into the everyday practice of a nurse and that is part of their practice-based thinking and learning.

Sloterdijk (2009) defined passivity competence as how nurses learn to become aware of what is going on by listening to others and observing the events around them. Iedema et al. (2013) argued that this reflective orientation enables nurses to develop a shared intelligence, which encourages them to observe and talk about what is 'taken as given', with a focus on in-situ practice. The reflective sessions with participants in the study facilitated this practice, feeling more like action research in some sessions where the participants experienced an intention to use this in their ongoing practice.

The nurses involved in the study were surprisingly interested by the moment-by-moment unfolding of their practice in the review of the interview transcripts and reflexive discussions following sharing reflections on observational fieldnotes. The interest taken on by nurses was a result of being confronted with open and transparent discussion about hospital policy and their observed practice, which was deeply familiar to them. It provided an opportunity for discussion about, and gave a new perspective to, an area of their practice that is mostly taken for granted. The reflective sessions offered participants an opportunity to re-experience and reinterpret the complexities and dynamics of their practice in their everyday work. This approach privileged and nurtured the knowledge and experience of nurses working at the frontline in their everyday practice; most importantly, it empowered them to use their nursing voices. It emphasised that challenging the way things are done is a healthy part of nursing professional practice and an important and fundamental professional function of nursing.

Processes of discernment and decision-making observed in nursing practice during the observational fieldwork were occurring frequently and required nurses to be able to recognise and appreciate any risks present in order to carry out a dynamic risk assessment. Participants who were experienced nurses demonstrated continuous processes of identifying patient

symptoms and assessing their clinical status. They were aware of potential areas of risk and clinical complications and took immediate action to ensure that patients were safe and comfortable by mobilising a range of tactics to manage the immediate risks and also put in place and evaluate plans to mitigate risks going into the next shift/day. These nurses were confident in their knowledge and skills, and they taught less experienced colleagues along the way, while ensuring that the patient was at the centre of their focus—keeping them informed, reassuring them, managing their symptoms and escalating to their treating medical practitioner. There were policies that dealt with these types of scenarios, but no one reached for them to read what to do at the time, or indeed reflected on what they said after the event.

Clinical events are likely to be constructed of many levels of complexity, and they may encompass both simple and complex dimensions (Lillrank & Liukko, 2004). For example, in the scenario where intravenous cannulation was a routine procedure undertaken by a nurse, a competency for nurses exists, but no policy was available in the hospital, and staff were referred to the Joanna Briggs Institute CPGs to guide practice. However, patients can have a range of clinical complexities and situations that challenge cannulation and affect access sites, such as vascular disease, dehydration or chronic renal disease. Multilayered events require teamwork and the use of collective skills and experience. In this scenario, the team leader sought other experienced nurses to cannulate the patient and then the house medical officer, again judging their levels of experience and competence to serve the patients' needs and minimise harm and discomfort for the patient. The nurse had her own "two attempts rule" before seeking another experienced practitioner, and while maintaining ongoing advocacy for the patient was reluctant to ask the house medical officer, known for taking up to five attempts to cannulate some patients. In this respect, nurses refer to their informal communities of practice for advice and support and to find an appropriate solution for the patient's clinical needs from the range of options available. This was the basis for a dynamic risk assessment and management process in complex operational incident environments.

Kahneman and Klein (2009) discussed whether following rules is safer than using intuitive expertise. They argued that task environments are high-validity and necessary for using intuition skilfully and adopting opportunities for learning, including practice feedback (reflection in action and on action), which all help to develop skilled intuition (Kahneman & Klein, 2009). They explained that real experts know when they do not know something, but not necessarily why they do or do not know. This was reflected in the participant vignettes. Inversely, novices and beginners do not necessarily know what they do not know. In this respect, subjective confidence is considered as unreliable as the validity of intuitive judgements and decisions. The authors described the fractionation of skills, where expertise in some tasks is called on to make judgements in other areas where they lack skill, such as where routine care is intersected by uncommon cases but regarded as routine care. For example, care pathways and clinical guidelines that offer a prescription for action may have limited accuracy given practical variance, but tend to have advantages over inconsistencies of practice without them. There is a distributed nature of clinical knowledge here that has not been well researched.

Patient safety and quality of care research has historically privileged technical, scientific and bureaucratic dimensions of care (Iedema et al., 2013; Leape et al., 2002; Shonjania et al., 2001). This has supported growing interest in research approaches such as narrative and ethnography. However, they have limitations in their ability to compare or aggregate data. This was primarily a result of their proximity to the in-situ complexity in the study approach. Looking at nursing practice through the lens of in-situ complexity reveals contradictions and surprises about what was really felt, thought and enacted. The reflective processes opened up a discussion that nurses know that their working day starts with a plan that will invariably change many times throughout the shift, and they will need to change tack, reprioritise, seek advice, support and re-evaluate decisions made again and again. It is important to understand how frontline nurses deal with ambiguity, change and complexity in their everyday work for individual nurses, team managers and policy drivers. It is important to conduct research and discourse in this area to help

be aware and understand the role that policies and procedures could play, where informed judgements and critical thinking are, and where they do not easily fit. This is a process of discernment that is continuously occurring, and information and judgements are being assimilated in nurses' every day work.

Researchers who study complex events need to adopt a complexity way of thinking and talking (Caroll, 2009; Iedema & Degeling, 2001). Nurses are creative and have to come up with solutions to problems as they arise. They did this often by working as a team. This type of teamwork was described Boreham (2004) as a collective competence. Nurses are attentive to others' actions and a way of communicating in which the mundaneness of daily encounters can hide the safety behaviours that are in evidence every day. This is particularly evident with experienced nurses working with students and less experienced nurses.

7.4 Knowledge and Communities of Practice

There was no pedagogy for learning from complexity, acting within complexity or how to prepare clinicians for adaptive practice or reflect on their responses (Iedema et al., 2013). Iedema et al. (2013) and Dryden-Palmer, Parshuram and Berta (2020) argued that studying complexity requires specification rather than generalisation where there is a dynamic relationship that needs to be understood between context, complexity and implementation processes for the uptake of evidence-based practice in healthcare. Understanding a specific event may still help nurses in their discernment about what to do in similar events later on. Most importantly, discourse on the specific event opens nurses up to a language of complexity and empowers them to reflect on practice with the opportunity to practice reflectively in and on practice in the future. In this way, we are developing skills to recognise complexity and mobilise wisdom and resources to deal with it as best we can—self-organising and collaborative. In their everyday work, the nurses were constantly searching for meaning and future possibilities and risks, planning ahead to keep the patient safe and provide quality of care. All of this occurred in a

context of uncertainty, and it is recognised that safety practice involves trade-offs that can only be brought into awareness when focusing on moment-to-moment practice or in-situ nursing practice. This implies the active participation of both the researcher and the participants in the study.

Clinicians have resources that are continuously evolving as practical wisdom, and reflective practice is a process for uncovering and opening up this wisdom to themselves and others (Iedema et al., 2013). Reflection is a practical tool for helping nurses to articulate their knowledge and share it with other nurses, healthcare professionals and patients, making their practice more explicit and valued. There was repeated evidence of this in the reflective sessions with participants. There is a growing body of research that supports the increasing complexity of care and demands higher-order thinking skills among nurses, emphasising the application of knowledge and experience to identify problems and direct clinical judgement and actions for positive patient outcomes (Benner, Hughes, & Sutphen, 2008). This process of critical thinking is stimulated by integrating knowledge, experience and clinical reasoning to support nursing practice in a paradigm that, for critical thinking and cognition, is social and dialogical. This supports Iedema et al.'s (2013) view of the importance of communication and dialogue in this process of moving towards safer care for patients and engaging in a community of practice. This requires nurses' active engagement to develop different thinking strategies, including critical thinking, clinical judgement and reasoning, deliberative rationality, scientific reasoning, creative thinking, and critical reflection articulated through their communities of practice.

Communities of practice that originated within the theoretical framework of situated cognition and that challenged the separation of learning and cognition from what happens in situ were described by Hara, Shachaf and Stoergor (2009). These communities of practice offer a potential solution to support the complexity of applying hospital policy to nursing practice. The term 'communities of practice' describe the systematic group behaviours exhibited by nurses when learning is taking place in situ, given that nursing is constituted within a process of lifelong

learning. Situated cognition has its origin in the theoretical framework of Vygotsky's sociocultural theory (1978), emphasising the importance of the environment in establishing positive, dynamic learning processes. Plaskoff (2012) later proposed that the apprenticeship model from which Wenger (2002) derived the concept of communities of practice and demonstrated these Vygoskian principles in action. Their original definition emphasised a form of apprenticeship that allowed newcomers to participate at the edge of a community while learning the lingo and developing an intuitive sense of the shared identity of the community. The end result of this process was assimilation into the community. The term has been adapted by others but generally focuses on fostering opportunities for knowledge sharing in a workplace and integrating learning in working as a bridge between learning, working and innovation (Brown & Duguid, 1991). The concept of communities of practice may be useful for articulating collective knowledge creation within organisations. This opens up opportunities for multidisciplinary healthcare professional communities of practice when focusing on patients across the continuum of care. These forums can create an authentic discussion of policies and nursing practice in targeted areas as living conversations rather than culminating in the sign off of a version of a document that was infrequently read.

The formation of a community of practice may hinge on something as simple as the opportunity to share work stories or safety stories in a social context. In terms of nursing groups, this could be described in the vignettes from this study as nurses worked with colleagues shift to shift. Shared meanings can be developed through communication among members of the community. Communicating effectively is important to contribute to the development of shared meanings, common language and tacit knowledge (Davenport & Hall, 2002; Fussell & Krauss, 1990; Plaskoff, 2012). Communities of practice are described as informal networks that evolve organically. In this sense, they are likened to relationships that develop over time between colleagues in a workplace. Communities of practice helped to develop a supportive culture. More importantly, members of communities of practice come to trust each other—at the very least, on

a professional level (Davenport & Hall, 2002). This would be useful in integrating novice, beginning, competent, proficient and expert nurses in a safe space for conversations about policy and nursing practice.

Learning as a group-level phenomenon was an essential part of everyday work practices when George, Iacono and Kling (1995) studied the effect of learning in context and affirmed the need for research to understand the links between learning and performance. Communities of practice need to be nurtured rather than imposed, and to challenge the predominantly top–down approach from management in relation to policy development and adherence. This could provide a resolution to the meeting of worlds, sharing of perspectives and understanding of both the top–down and bottom–up approaches and views.

Adaptive learning was described by Senge (1990) as learning via adaptation to routine as opposed to "generative learning", where learning evolves as a result of reflection. However, this may simplify what is a much more complicated process, as it is more difficult to determine how learning takes place on an organisational level and at the frontline of nursing practice. Knowledge can be analysed as an active process of knowing using a social constructivist paradigm. Within this paradigm, knowledge is viewed as both an individual and a social process because it is viewed as being constructed individually and collectively (Blackler, 1995; Lane, 1998; Orlikouski, 2002). This is evident in the safety stories that nurses described in relation to practice areas such as setting intravenous infusion pumps to alarm every two hours to ensure patient assessments are conducted. Although the policy does not require this, the nurses collectively thought it was a good idea to practice safety.

There are potential traps that communities of practice may fall into when sharing knowledge: the management trap, the individual learning trap, and the information and communication technology trap, where top–down knowledge management strategies often fail (Huysman & de Wit, 2004). This raises a warning for policy development processes for

hospitals, which may tick a box for accreditation or jurisdictional requirements but do not truly integrate knowledge and practice into local communities of practice. The authors contrasted this with a more effective learning process, described as a grassroots initiative, in which a group of professionals engage in informal learning within their community of practice. However, this unstructured approach to learning may contribute to a mosaic of safety learnings being distributed across communities of practice and varied mosaic patterns of learning across organisations, where gaps in key safety learnings may be highly person-dependent in terms of access and embedding into nursing practice.

Traditional situations for supporting individual learning, such as conventional instructor-led classes and database searching, are difficult to transform into socially shared processes, and some types of tacit knowledge are difficult to share (Huysman & de Wit, 2004). It is important to examine why people share knowledge. Unintentional and natural learning is situated learning that occurs in workplaces (Wenger, 2002). The paradox lies in the fact that while situated learning is difficult to manage, it is often much more effective than purposeful learning (Hara & Schwen, 2006). This raises questions about the practical effectiveness of implementing hospital policy or education strategies as recommendations following a system review of an adverse event. These are recognised as administrative controls in terms of a risk management hierarchy of control because they are easy to implement and they demonstrate action to regulators and accreditors. However, they are challenging in measuring effectiveness, and they embed safety awareness by creating a community of practice following an adverse event. A worker's motivation for learning is an important precondition and cannot be designed. However, Wegner (2002), like Brown and Duguid (1991), proposed that learning can be facilitated, and it is important to recognise the value of communities of practice and work towards providing a nourishing and learning environment.

One of the roles that communities of practice play is to provide an environment for professional socialisation within which members may develop their professional identity. This

has implications for nurses across the novice to expert continuum, as nurturing the development of nurses across this continuum can occur positively in a community of practice where incidents and events have occurred, and system review processes can provide support in the learning and development of individuals and nursing teams. This could provide opportunities for developing and sharing safety stories throughout an individual nurses' professional development and across a community of practice in a ward or department within a safe space nurtured for sharing and learning and growing professionally.

7.5 Communication and Nursing Narratives

Teams with different knowledge and skills are the key to safely practicing in complex healthcare environments. Communication within teams is the key to the discourse on safety and an ability to deal with complexity and practice, individual healthcare professionals and within communities of practice in the discernment of skills to manage all levels of complexity. This emphasises a broader conception of safety that requires nurses to be practicing as part of a healthcare team or community of practice that proactively collaborates so that their skills and knowledge come together to meet the range of complexities faced in their everyday work. For example, this was evident where a reflective practice session was held with one participant in relation to patient falls prevention and management. This experienced nurse acknowledged that she had never read or seen the hospital falls prevention and management policy. However, she was fully aware of the essential elements of the policy and the practice requirements outlined based on best-practice falls prevention. An audit of a random selection of medical records from the ward relating to patient falls and analysis against the falls policy requirements reinforced to the nurse participant that there is general compliance with documented care to the requirements of the policy. This was in part due to the form designs that provide guidance for nurses in falls risk assessment and implementation of appropriate strategies. However, there is also an element of subconscious consciousness in that she did not know how she knew, but she knew what the good practice requirements were. Further, before the reflective session, she acknowledged that

this was something that she had not previously thought about; however, since participating in the study, it was starting to make sense to her. Now that she views falls policy and prevention/ management differently, there are many other areas of clinical practice that she began to ask herself questions about.

Nurses have long shared stories and habits, which are reflected in the study vignettes of safety and other stories promulgated into nurses' every day practice. This exnovation, where nurses cannot currently innovate policy into practice, could be legitimated through reflective processes to consciously appropriate habits and knowledge among nursing workgroups, where there is limited evidence of this actively or explicitly taking place in a conscious manner. Observational fieldwork has enabled the participants to concentrate on this appropriation of hospital policy knowingly and to consider how they unknowingly practiced policy that may otherwise have been considered mundane. However, nursing practice, which is often viewed as mundane tasks in assessment, implementation of care and evaluation of activities of daily living for patients, is what fills much of nurses' every day work. This study has focused on policy and nursing practice, which has made tangible a space for awareness and understanding of nursing practice.

Challenges in researching every day practice requires continuous communication about the application and processes around rules. The importance of communication as critical to promoting safe practice amid the complexity of every day work in healthcare was emphasised by Iedema et al. (2010), because genuinely knowing everything in such circumstances is unlikely. This approach was supported by Jorm (2012), who found that even experienced clinicians are often uncertain in complex settings such as healthcare. On this basis, a commitment to lifelong learning as a healthcare professional is seen as the key to safe practice and indeed professional practice, and was reflected as such in the NMBA's (2016) Registered Nurse Standards for Practice.

These interactions were observed at the margins (e.g., corridors, pan room, treatment room), where there were disconnected conversations as nurses ran into each other and opportunistically had conversations and asked questions (Iedema et al., 2010). While these conversations allowed great freedom in language and context, the participants in this study were surprised to find how often these conversations took place when they listened to their words and language in the reflective sessions. This freedom and informality allowed the participants to raise issues foremost in their thoughts and resolve them quickly at the time, or to adaptively orient what was significant through more formal professional processes, for example, going to the team leader or ward manager. This communication at the margins focuses on in-situ nursing practice through a lens of in-situ complexity. This provided an opportunity for managers to open up the voices of nurses in zones of collaborative attention to listen to what was being said and done behind closed doors.

Conversations taken verbatim during both interviews and observational fieldnotes demonstrated the frequent use of truncated sentences by nurses. Further, there was a significant element of humour in many interactions with more experienced nurses, and a reasonable amount of swearing out of earshot of patients and senior management. This was observed where nurses started a sentence and half-finished it, and their colleague finished it or understood the gist and progressed the conversation with a common understanding. It may be that in a community of practice, there are pre-existing knowns that provide context for many conversations relating to nursing practice, distributed knowledge about care and practice elements that enable insiders to understand these truncated and abbreviated meanings.

The lens of viewing nursing practice through hospital policy enabled nurses to make the moment-by-moment aspects of practice visible in complex contexts that occurred in the nurses' every day work. When opening up to new perspectives in this way, there was a need to develop professional tolerance for different perspectives and knowledge. This means that nurses should be interested and open to what their nursing colleagues are saying and doing, and encouraging

questions about the appropriateness of doing and saying. Professional curiosity and respect underpin the approach of trusting each other's positive intent to strive for safe, quality and appropriate patient care and experiences.

Hospital policymaking has been viewed as a way of making evidence and safe practice visible. But we now know that nurses practice many other areas of safety that are not covered by existing policies. Bate and Robert (2003) questioned a trend in patient safety research and policymaking that disregarded that which nurses already practice in safety. These existing sources of safety were given prominence by Iedema et al. (2013) because they were often unrecognised and underappreciated. They encouraged the use of reflexivity to help make these safety practices visible to reveal their potential. They highlighted that good practice can be affected by poorly designed tools and, for that matter, policies and forms. This was seen in the vignettes when a policy on falls prevention and management and pressure injury prevention and management were inconsistent with the form design for these areas. Ironically, good form design can be a forcing function that assists nurses in practicing policy without them even being aware of what the policy required. For example, if the policy requires a falls risk assessment upon admission—post-operatively, weekly or whenever the patient's condition changes—then the form design should mirror this to drive practice. However, the study sites demonstrated many examples of mal-alignment between policy and the forms that supported nursing practice. This was particularly evident where risk assessments were required to be undertaken and the form design limited flexibility in this area. Variance forms are often implemented as a catch-all for nurses to record anything that varies from standard practice; however, they appear to be poorly or inconsistently used and understood.

Through interviews and observational fieldwork, participants were able to articulate their practical knowledge. They described their own safety stories as examples of practice-based experiences that formed their understanding of practice to ensure patient safety. The researcher found commonalities in safety stories across nurses in different hospitals around setting

intravenous infusion pumps to alarm every two hours to ensure they reviewed their patients regularly, even if their workload increased significantly. There seemed to be a lack of a coordinated approach to nurses sharing their safety stories and collective knowledge through encouraging broader discourse and learnings and a general lack of awareness that this is what they were doing in their everyday work.

7.6 Practicing Safely

Nurses consistently demonstrated an explicit intent to focus on caring for their patients' safety as individuals in this study, even if it was at the expense of paperwork or administrative duties. The participant nurses described reading policies as part of their administrative work, and they relegated this to the least interesting or desirable area of nursing practice. They said that it was what they did last, after all patient care was done, unless they really had to know how to do a procedure and there was no one around to ask.

Safe practice is derived from the systemisation of procedures and guidelines and from staff being able to adapt to every day unpredictable moments (Bruni, Gherardi, & Parolin, 2007; Caroll, 2009). The authors described unpredictable predictables and unpredictable unpredictables, which is the importance of recognising that while policies, procedures and guidelines help staff to prepare for practice through established systems and standardisation, they are largely silent on helping staff to deal with unpredictable moments. This is where the approach of lifelong learning, reflective practice, sharing safety stories, collective competence and communities of practice start to reside.

Reason (2004) wrote about error wisdom, which is a kind of knowledge or mindfulness that characterises how nurses keep patients safe. This is reflected in nurses' safety stories shared with less experienced nurses—in particular, in relation to the use of high-risk medications and intravenous therapy. This may support Bruni, Gherardi and Parolin's (2007) zones of collaborative attention, in which experienced nurses model practice behaviours for novice and

beginner nurses. However, if the practice is undertaken without a conversation that places meaning on the behaviours, there is a risk of nurses operating in a task-oriented mode due to power structures rather than a thinking healthcare professional mode, or as some participants explained, when you do not know something or your gut tells you that something is not right, go and ask:

> "a clever old nurse".

According to Weick (2001), understanding how clinical staff make sense of their work and policies and procedures is one way to assist this process. Sense-making relies on communication between people to discuss unpredictable moments (Iedema et al., 2013). This was represented by the nurses who shared their safety stories and practice-based experience, in particular, more experienced nurses teaching or orientating less experienced nurses to the ward. Much of this communication occurred in corridor conversations and when nurses asked other nurses for assistance, which may be behind closed doors (e.g., patient bedrooms or bathrooms, pan room, treatment room, tearoom). During the study, the researcher followed the participants everywhere and observed much of this incidental communication, which was fragmented. Participants were observed walking past the staff station/reception area and, catching the end of a conversation, they would stop and add their perspective or a small piece of the patient's management or experience that they held witness to. It was also evident that less experienced nurses tended to ask different colleagues the same question to gauge consensus. They did not always go directly to the team leader or most experienced nurse, and they almost never looked up a policy.

The participants recognised the role of clinical resilience in the vignette, or how nurses adapt to high-risk clinical situations, failures and workarounds (Jeffcott, Ibrahaim, & Cameron, 2009). Workarounds may be so relevant to every day practice that they are promoted as standard practice (Hollnagel, 2008). However, awareness and understanding of these workarounds is an

important part of self-reflective practice and team discourse in order to discern and make decisions about their effectiveness or otherwise. The awareness of variation in practice also highlighted that if there is no way to legitimise the discussion of workarounds and the part they played in patient safety, then communities of practice would continue to struggle with raising awareness, exploring understanding and proposing action to improve safe in-situ clinical practice.

No single nurse in a ward can know everything that happens behind closed doors, in rooms and down corridors. Thus, the nursing team on a shift has to find ways to communicate as work unfolds throughout the day. There are so many aspects of safety that unfold every day in a nurse's work, and information knowledge sharing is a key part of a nurse's individual and collective practice responsibilities (Hutchins & Burke, 2007). There were formal opportunities for nurses to talk about their work at the start of a shift "huddle" of handover, during the end-of-bed handover, between shifts with nurses and patients, during doctors' ward rounds or during hourly formal rounding of nurses, and there were many informal moments, corridor conversations, tea room conversations and other opportune spaces.

These nurses were acting on adaptive behaviour (Caroll, 2001). They pull together different types of knowing to come up with a workable way forward, knowing that this may change again at any moment. The nurses observed in this study were surprised about what they knew and how they made decisions. Reflection in practice was a key approach in helping the nurses articulate what they knew and felt with colleagues in order to understand what they have become aware of and to enable them to make a decision and take action.

A method needs to be developed that can enhance a team's confidence in interpreting and deploying resources to strengthen safety capacity and develop a more articulate distributed intelligence in the workplace (Iedema et al., 2013). Whether this can truly be achieved within the cultural context of hegemony that is pervasive in healthcare is unclear. However, nurturing

communities of nursing practice and actively encouraging continual learning is a positive step in the direction of building and strengthening amore articulate and distributed nursing intelligence to promote patient safety and quality of care in a complex environment such as healthcare.

Knowledge interactions with policies and procedures are constantly in play during every day nursing practice, and experienced nurses were attentive to what was happening moment to moment in their practice and in the practice of other nurses in their work area. There was a professional, cultural and safety practice in nursing to advocate for patient care and safety at all times, which meant maintaining awareness for opportunities to nurture less experienced nurses so that they in turn would nurture other nurses in their everyday practice. Sometimes this was played out by the team leader or nurse manager, and sometimes it was played out by the researcher and an experienced nurse and manager. This also demonstrated the distributed nature of knowledge of policies and procedures.

Some events and scenarios may require a truly creative response beyond the linear, scientific approaches and application of bricoleur principles of nursing practice. The existing incident and system review processes focus on how practice should be performed based on policies, procedures and evidence-based practice rather than in-situ or every day circumstances. Work continues to become ‘communication-intense’ (Deetz, 1995); it is the important medium through which nurses resolve complex problems in their everyday work. Research needs to focus on this area to observe how nurses engage with each other, their patients, families and other staff.

Nurses often practice in complex settings, with ambiguity, and they may be time- and/or resource-poor. However, informal communities of nursing practice exist within hospital workplaces, which means that many nurses do and will continue to communicate with other nurses to check their awareness and understanding to practice safety in their everyday work. Encouraging and nurturing opportunities for nurses to engage and communicate with each other,

their patients and families and other healthcare professionals is important to ensure that curiosity and intuitive questioning are part of everyday nursing practice.

Futuring the present is a term used to describe nursing assessments that are continuous and important for seeing possible scenarios of potential patient harm. This is consistent with Reason's (2004) error wisdom concepts discussed in chapter two, related to a process of dynamic risk assessment and risk management that has become such an important part of healthcare. Through individual nursing experience, education exposure to communication and clinical events of other nurses, the range of insights into what can happen and what can go wrong has built the repertoire of nursing skills. Nurse participants spoke of just knowing that something was not right, or seeing what could go wrong and putting things in place. This knowledge and awareness of what could go wrong came from a background of many years of nursing practice experience and either practicing or observing other nursing colleagues in practice.

Most of the time, policies seem to be in the background until someone asks: What does the policy say? This assumes that a policy or procedure exists and that it will provide an explicit answer for the particular scenario. It also assumes a concern on the part of the nurse to follow the rules to avoid getting into trouble, and to do the best thing for the patient's best and safest outcome. The meaning of safety was considered by Hollnagel (2012), who argued for a broader understanding of safety within ordinary and every day practice rather than that arising from incidents and adverse events. This makes sense when one considers the studies that compare incident reporting rates of adverse events, with medical records consistently citing rates little better than 10–17%, as highlighted in the Australian Quality in Health Care Study (Wilson, 2005).

Nurses' knowledge of policy compliance and non-compliance has primarily come from incident and adverse analysis, so nurses know when they have not followed a policy and something bad happens. However, they do not have a way of knowing when they follow a policy

and something good happens, or when they follow a policy and something good still happens to the patient. Focusing policy review as a reaction to incidents and adverse events seems to be the easy way to deal with a small piece of the complex healthcare puzzle. This clarity of faulty versus successful practice was challenged by Iedema et al. (2013) as a tenuous description. This raises questions about a continuum of practice that is 'safe enough'. Even a policy or procedure has the potential to be interpreted and enacted in such an unpredictable way that it becomes unsafe or results in patient harm. This flags the reality of trade-offs that are made by nurses in their everyday work for best patient outcomes—whether it is explicit and knowing or implicit and unknowing on the part of the nurses working in that space. Even with the best intention, the health of individual patients can deteriorate unpredictably. Further, there is great complexity in how patients perceive their care and their experience. Patients may experience harm but may relate to a good hospital experience.

Having to defer to rules, policies or procedures may help some nurses to practice safely in complex situations, particularly beginner nurses or those who are unfamiliar with the particular clinical setting. Safety in complex healthcare settings is contingent on forcing functions, resilience and innovation from within (Iedema et al., 2013). Forcing functions such as policies or procedures provides methods for practice, as can forms if they are aligned to policy. Conversely, mal-alignment of forms and policy can contribute to systematic failures that affect patient safety and quality of care. They may influence practice in scenarios where limited skills or high risk exists to optimise the chance of safe practice being followed.

Speaking about practice (e.g., during bedside handover) emphasises the significance of open communication about every day nursing practice and relevant policies and procedures. Huddles, handover and rounding provide a few opportunities for nurses to discuss what is actually occurring. Normal–legal thus follows policies and procedures, a supposed safe zone where nurses can share with other nurses and their patients in questioning and learning according

to (Amalberti, Auroy, Berwick, & Barach, 2005). This is a kind of discussion space that supports the development of distributed intelligence.

Clinical incident reviews have historically focused on where nursing practice falls short of idealised policies and procedures. However, this study has uncovered a richness of existing nursing practice that may still be safe and appropriate, and where nurses practice policy without even knowing what was written in a policy or procedure. Critical thinking is evident in nurses' every day work, which illustrates how nurses' practice through complexity. Nurses focus on patient-centred care and safe practice that goes beyond the prevention of incidents and adverse events. In their everyday work, the nurses did not seem to focus on deficit thinking in terms of incidents and errors (Dekker, 2006; Messman, 2009). Focusing on incidents or potential patient harm was often silent in discussions in the everyday practices and experiences of nurses, with incident analysis generally looking for what went wrong rather than what went right. This type of incident analysis focuses on systems; thus, the opportunity for individual nurses to reflect on their own practice to become aware and understand opportunities for change in their own practice may be less important than the lessons learned for the community of nursing practice.

Nurses and patients being able to discuss incidents and events within their own context and experience was consistently advocated by Dekker (2006, 2011). These discussions were described as meta-discourses that acknowledged individual experiences, both positive and negative (Iedema et al., 2009). This was where nurses, patients and others involved in care were entangled in the complexity of practice that did not privilege thinking and talking about what was happening and why. The space where every day practice unfolds. That is, the normal–illegal, was described by Amalberti et al. (2005), where practice related to what was possible rather than just what was required. This space was made up of workarounds or shortcuts that were not explicitly sanctioned by management. This space emphasises the discretionary nature of nurses' every day work, where nurses need to determine what rules need to be obeyed and how,

and where they rely on their practical knowledge to navigate this space effectively, which Amalberti et al. (2005) called phronesis.

Clinicians can drift into zones of error and patient harm if they do not recognise where their practice sits in the space of normal–illegal (Dekker, 2011). From this perspective, patient safety relies on communicating about every day practice and building distributed intelligence in a community of nursing practice. An important part of enhancing safety is to evaluate every day practice and regularly check whether workarounds and shortcuts are moving into poor or safe practice zones. However, this means that nurses have to consciously recognise these workarounds and shortcuts for what they are.

A study of nursing students and the usefulness of narrative pedagogy strategies in assisting in problem-solving in a clinical setting was conducted by Brown, Kirkpatrick, Magnum and Avery (2008). While pedagogical approaches for nursing student education is important, there is a gap in the continuity as nurses enter the workforce, and individual healthcare providers take on varying approaches and resourcing to staff and professional development. There is a growing trend to develop professional practice models for nursing, which is an explicit requirement for the magnet recognition program and accreditation by the American Nursing Credentialing Centre for hospitals; however, many healthcare organisations have taken an explicit approach towards improving quality and safety for their patients in this direction.

It is important to approach incident and adverse event analysis in a manner that seeks to recognise what nurses do well and what they do not do well, and to make space for individual nurse reflective practice and reflective opportunities within the community of nursing practice. This means that those facilitating incident analysis and investigations also need a clear pedagogical framework that develops and recognises core principles that address and support individual and distributed knowledge for learning from experiences that occur in every day practice. This discussion leads to recommendations for practice.

7.7 Conclusion

This discussion of the relationship between hospital policy and nursing practice has highlighted a complex argument of the rhetoric and realities of in-situ nursing practice. In conclusion, this study contributes to the body of knowledge regarding hospital policy and nursing practice. Whether nurses knew and followed hospital policies and procedures or did not know the policies and procedures but provided appropriate and safe nursing care, there is little evidence or research that supports the suggestion that patient care is safer as a result of only following published hospital policies and procedures. This is primarily because much of the knowledge around this area is based on auditing and incident analysis and does not adequately provide a study of the aspects of nursing practice that will result in safe and appropriate care where policies or procedures have not been followed or exist. In this sense, numerical data, key performance indicators and other published healthcare metrics are not able to provide insights into the complexity of qualitative data required to fully understand this phenomenon.

This study has provided supporting evidence of the importance of individual nurse reflectiveness, as well as the responsibility of all nurses to be self-aware and aware of others in order to make safety communication and conversations a normal part of everyday practice, where all nurses have an opportunity to learn and grow. Knowledge of individual policies and procedures, the pedagogical framework within which they sit and how nurse learning and development sit within the organisation is an important part of formation for all nurses.

Policies and procedures are one part of the jigsaw puzzle that comprises the components of clinical governance in healthcare. Incident reporting and analysis are another key part of the puzzle. Other parts of this complex puzzle include professional practice models that are integrated into the everyday practice of nurses, communication strategies that nurture formal and informal discourse between nurses, patients, other healthcare professionals and managers, and ways of thinking and learning. Complex adaptive systems, such as those that exist in hospital

settings, require different ways of learning and problem-solving compared with traditional linear scientific methods that have prepared nurses to work in this environment. This study has provided a perspective of hospital policy and nursing practice from the voices of nurses in their everyday work. The final chapter, Chapter Eight, concludes this thesis by outlining the achievements of the overall study aims and summarising the study's conclusion.

Chapter Eight: Conclusion

8.1 Introduction

Patients continue to experience unintended and preventable harm every day, and errors continue to be inevitable because nurses are treating patients with increased complexity. This chapter sets out to summarise what has changed in knowledge regarding the relationship between hospital policy and nursing practice as a result of completing this study. The key message arising from this thesis is that nurses confront the problem of the policy-practice relationship every day, and that continually reinforces to them that policy is not what they thought it was. The nurses in the study have shifted from a position where policy dictates what they do, to a paradigm of nursing and policy in an active relationship. What in the past was banal and had a variable relationship with them is now more central to nursing practice change and reform, which privileges nurses' voices, and places patients at the centre of care for safe and high-quality practice. This reflects their ability to translate a very rigid understanding and meaning of knowledge for practice into a dynamic language and conversation within the context of organisational learning and person-centred care. When nurses engage in practice, they become alert to specific issues and need a means of connecting their practice to policy. Modelling of clinical wisdom is what occurs in nursing in their everyday work. This further challenged the clinical governance paradigm that is currently politically driven in healthcare systems, whereby audit figures and key performance indicators are privileged over frontline nursing interactions. This blurs the reality of what occurs in nursing practice that was based on opinion or fact, and the number-driven paradigm of indicator and incident reporting that did not adequately demonstrate or explain how nurses were acting on knowledge of their practice.

This study also emphasised the compliance, medico-legal interpretation, coronial and public media interpretation of policy as a concrete set of rules that must be followed, or the nurse and their practice is considered non-compliant. This means that nurses continually need to justify

the variance or deviation from policy, where their inscribed practice is increasingly problematic. This creates a strong authoritarian gaze towards policy development, implementation and evaluation and may have contributed to this dilemma of policy. Many nurses seem to know that there are problems, but the dominant lens through which policy is viewed by many nurses does not support open and honest dialogue about what really occurs at the frontline of nursing practice. The reality is that most nurses, particularly experienced nurses, do not read policies. Instead, to practice safely, they rely on their past knowledge and experiences, intuition or tacit knowledge, and critical thinking and clinical wisdom. The power dynamic around policy and nurses is evident in their everyday work. In such a complex healthcare environment, there can never be too many rules or guidelines to practice that cover every aspect of practice, and if there are, then nurses cannot read or remember all of them. This suggests that healthcare needs to move towards a more negotiated way of practicing, which means better communication, developing relationships, engagement and language.

8.2 Achievement of Overall Study Aims (Phases One and Two)

The overarching aim of the study was to understand the relationship between hospital policy and nursing practice from the perspective of nurses in their everyday work. The aims were achieved by identifying what was known, understanding the multiple views and contexts, and then describing the relationship between hospital policy and nursing practice in the everyday work of nurses. Further, the study showed that frontline nurses play a key role in developing awareness and understanding the nature of policy and practice. Asking frontline nurses to relate their experiences of hospital policy in their everyday practice also validates the initial concerns about the challenges relating to hospital policy and nursing practice.

The study explores and describes the notion that nurses rarely read policies and procedures relating to their work practices within a complex healthcare environment. This is despite the governance, regulatory and professional practice standard requirements to do so.

There is little dispute that policy and procedure documents should be evidence-based to promote the delivery of safe and appropriate care to patients. However, the initial anecdotal experiences of the researcher working as a nursing leader within a clinical governance context identified concerns about the rhetoric around policy processes and its use in nursing practice. The study reinforced that nurses are expected to read and understand a large number of policies and procedures and apply them in their everyday practice, but it is unrealistic to expect nurses to read and understand every such policy. The evidence that nurse participants do not read policy documents and yet still apply nursing practice that is generally consistent with the intent of the policy is an important finding in the study. Whether nurses read the policy documents or seek evidence-based approaches to care from a trusted colleague or a direct source reflects the fact that reading and following a policy document is not common practice for nurses in the study. However, the nurses demonstrated that they practice safely and appropriately in the study, despite not having read the many policies relevant to their practice.

The study's aims were therefore achieved, confirming that there is a problem with hospital policy and nursing practice when viewed through a clinical governance lens. This provides a further consideration of what this means for clinical governance in current healthcare settings. A number of recommendations have been developed to provide further explanation of a proposed pathway forward.

8.3 Summary of Recommendations

These recommendations reaffirm that hospital policy and nursing practice are not what we think they are, and they highlight the need for a greater conversation and understanding of this complex space:

1. Considering a new clinical governance frame of reference for policy: The review of clinical incidents and adverse events using RCA and other methods of analysis highlights the notion that policy is not what we think it is. Hence, categorising policy non-adherence

or non-compliance by nurses requires greater consideration and a different mental model. A clinical governance frame of reference is needed where policy and evidence-based practice inform nursing practice context for safe and appropriate care and where practice in turn continues to inform policy and evidence. This is a more rational approach than providing a binary or definitive expectation that everything is reduced to a written policy that is always written according to best available evidence, and which all nurses must know or have read in order to practice appropriately and safely at all times. Policy non-adherence or non-compliance is no longer a dominant way of thinking; rather, it reflects that the complex role played by policy, evidence-based practice and practice-based evidence in clinical outcomes is of greater importance than a compliance-driven rhetoric;

2. Recognising the role of communities of practice in integrating policy and practice: Nurses who practice in hospitals do so within a community of practice and use their professional networks and experiences to learn and develop. Professional practice standards, governance and regulatory and accreditation standards that continue to suggest that all nurses should know the relevant policies related to their practice are fundamentally flawed. There are opportunities for these bodies to support nursing practice and development by recognising and leveraging the way that nurses already learn and work rather than the over-simplification of applying compliance frameworks to drive good practice;
3. Understanding the importance of critical thinking, clinical judgement and reflective practice supporting policy as a guide to nursing practice: Nurses are constantly dealing with change in the complex environments they work in every day, and they are continuously learning and developing their knowledge and skills by facing challenging clinical situations. This study demonstrates that policies and procedures generally function as guides to practice. Some nurses seek them out, but most do not because they find evidence and best practice from other sources. This requires critical thinking and

variation based on individual nursing assessments of the particular patient's needs or situation, as well as clinical judgement. Further, reflective practice is a core learning tool used in every day nursing practice in which nurses consider their actions and outcomes individually and collectively, and they learn and adjust for future practice;

4. Recognising the nature of in-situ nursing practice and its effect on policy: The ambiguity of nursing practice also creates a better understanding of the nature of in-situ practice, every day decisions and actions of nurses in practice, and their relationship to policy. Many practices are not reflected in policies because they either do not exist or they have been surpassed by evidence or the clinical situation presenting itself to the nurse to practice through. However, the instantiation of good nursing practice was seen to be at the core of nurse intention and actions within this study. Written policy played little part in that process in reality;
5. Reconsider the dominant role of policy in practice standards and compliance frameworks: The result is a challenge for regulatory and accreditation bodies to reconsider the dominant role of policy in their standards and compliance frameworks. In complex healthcare settings, the evidence is not strong that written policies or procedures in and of themselves can be directly attributed to good nursing care and hence good clinical outcomes; rather, they are reported to highlight poor practice. Given the large amount of nursing practice that occurs every day, the evidence of policies that are not followed resulting in poor clinical outcomes is biased because there is limited evidence of research into good practice undertaken without reading hospital policy. This unresolved ambiguity will remain a challenge for policy implementation under the current accreditation and compliance-driven regulatory models of practice in Australia;
6. Encouraging lifelong learning for nurses: Evidence-based policy is recognised as important for patient safety and clinical governance internationally; however, the manner in which policy is implemented is the key to whether it is applied in frontline clinical

practice as intended to improve the safety and quality of patient care. Clinical governance is a systemic approach to integrate the components of the hospital to continuously improve standards of care and support the safe and quality provision of patient care. The findings of this study support this approach, emphasising the importance of lifelong learning for nurses where they develop knowledge and skills in practice and engage in communities of practice and reflective practice in their everyday work. Policy and procedures have a role to play in this governance approach to good practice, but it is not the panacea of compliance and assurance that is purported by accreditors and regulators to achieve safe and appropriate practice;

7. Encouraging open and authentic discussion about the relationship between hospital policy and nursing practice: The problem of policy not being openly discussed by nurses, managers and regulators is significant. Nurses reported that this is because it may adversely affect their practice standards and employment agreement if they openly acknowledge that the policy has not been read or followed, or that it was not important to their practice. The ability to undertake system reviews relating to adverse clinical events requires an open discussion about the reality of clinical practice and complexity in healthcare. The linear problem-solving approach of RCA and other types of system reviews is inadequate in dealing with the complexity of in-situ clinical practice. This approach positions policy non-adherence or non-compliance as an intermediate or root cause in an adverse event, and this is simply too simplistic for application in complex environments such as hospitals. A move towards other models of incident analysis that recognise the complexity of clinical practice is urgently needed to assist in creating new mental models of clinical governance, incident management and analysis; and
8. Designing nursing practice with forcing functions to assure policy: Documentation or electronic pathways that drive evidence-based practice are more effective in achieving practice standards than relying on staff education and reading policies, which were

evidenced as low-level administrative controls requiring little effort but having a limited effect. Frontline nurses suggested attaching laminated procedures to equipment so they are visible to nurses when they need to use the equipment. Building care processes aligned with policy into forms and electronic pathways is a type of forcing function that assures policy adherence by nurses as part of their everyday nursing practice without them having to read a related policy.

8.4 Significance of the Research

This study emphasised the significance of this research to nursing practice. It has raised awareness of the reality of the relationship between hospital policy and nursing practice in the context of clinical governance. The key message from the study's findings is the need to rethink the role played by hospital policy in every day nursing practice to maintain safe and high-quality care within the complexity of every day healthcare settings. Further research and ongoing discussion on this topic will enhance the exploration of what is known about hospital policy and nursing practice in the hospital context.

8.5 Recommendations for Further Research

The findings of this study emphasised the importance of effective critical thinking, reflective practice and communication as core components of nurses practicing policy safely and promoting quality of care. Understanding the many variations in how nurses effectively manage their day-to-day practice within a policy space, at different stages of experience and development across a range of clinical settings, was challenging. Further research in this area using a broader range of frontline nurses and clinical settings and implementing the above recommendations could assist in the development of a pedagogical framework to support and evaluate ways for nurses to consciously practice policy dialogue and competence. Such a framework that aligns to professional practice standards and accreditation or regulatory standards would be a valuable and

practical way of embedding the relationship between hospital policy and nursing practice into the everyday work of nurses.

Although the aims of this study were achieved, there were limitations on what could be analysed, as reflected in the recommendations for future research. In the approach undertaken in phase one, only ten nurses from one private hospital were interviewed regarding their views on hospital policy and nursing practice, which limited the range of nurse participants' perspectives. Some of these nurses were frontline workers, but others were in middle and senior management positions. Thus, the voices and understanding of frontline nurses' experiences were narrow. However, this cross-section of nursing experience strengthened the study's findings by demonstrating a range of differing perspectives on the effectiveness and utility of hospital policy in supporting nurses to deliver safe and high-quality care. The nurse participants shared their views and emphasised their nursing voice on this subject that may seem banal on the surface, but that is rich with context once explored. While this approach was efficacious in terms of time and cost, it bounded the exploration of policy and nursing practice to the lived experiences of the 10 nurse participants in the one hospital setting. There are questions remaining in relation to understanding and describing the relationship between hospital policy and nursing practice, and how to improve patient safety and quality of care. Phase one found that challenges exist in relation to how policy and nursing practice are viewed by participants, and phase two provided observational validation of every day nursing practice with the phenomenon across broader healthcare settings, with a focus on frontline nurse participants.

The overarching recommendations for improving the relationship between hospital policy and nursing practice relate to approaches that support how nurses learn and develop professionally in their everyday work. The study found an underlying issue for nurses who need to apply practical knowledge to in-situ practice in their everyday work, regardless of their level of experience or knowledge where policies exist and where they do not exist. There were already informal communities of practice, professional socialisation and unstructured mosaics of safety

learning emerging from situated learning scenarios in nurses' every day work as they nurtured professional socialisation across the novice to expert continuum. The recommendations for further research are to explore:

1. the role of professional practice models for nursing using a pedagogical approach to plan and nurture how different types of learning and knowing translate into nursing practice for novice to expert nurses;
2. the role of communities of practice that emerge at the margins during predictable and unpredictable moments of nursing practice and that are often disconnected but provide opportunities for zones of collaborative attention and nursing practice at the frontline;
3. the role of reflective practice for in-situ learning in every day nursing work; and
4. the role of critical thinking and clinical wisdom to develop and grow nursing practice in dynamic risk assessment approaches to safe and effective care.

8.6 Conclusion

Policy does not make sense to many nurses in their everyday work. This thesis challenges mental models about hospital policy and nursing practice—a problem that has not been openly acknowledged and that has no easy solution in complex healthcare environments. The primary reason for undertaking this study was to first understand and then challenge the way nurses, managers, executives, accreditors and jurisdictional bodies shape the discourse around policy and nursing practice. In a simple organisation, cause and effect is evident, there is little variation or emergent practice, and it makes sense to operate under policies and procedures that directly relate to practice and where compliance is visible and measurable. However, in complex organisations like hospitals, this linear causal relationship, with the premise that following policy and procedures with nursing practice at all times equals safe and effective patient care, is not self-evident.

This study demonstrated that policy has a tenuous grip on every day nursing practice. Nurses practice policy but cannot always talk about it, and they are often not even aware of policy context or effect. Policy-makers and other key stakeholders in the policy space need to develop insights and acknowledge the importance of considering different ways of thinking about policy. Without examining what is occurring in in-situ practice, it is difficult to know whether what occurs in practice actually works all the time, and what innovative workarounds have been embedded in nursing practice. Nurses need to be connected with how they work together and align policy to practice tacitly or explicitly. Understanding the lens through which frontline nurses view practice within their own sphere of complexity to create relationships in the workplace is important. The ability to engage in influencing frontline staff is critical, as is reaching a consensus to negotiate and shape how they practice in a positive learning approach that recognises the inherent practice–policy gap.

Nurses need to find opportunities to share their voice proactively with regulators, accreditors and managers regarding the reality of every day practice. This means challenging the rhetoric around the role that policy plays in every day nursing practice and reducing patient harm, as well as the structures, processes, leadership and local workplace culture that are required to be embedded for policy and nursing practice to be truly integrated. The study's findings show that the current mental model is simplistic and may even contribute to poor patient outcomes and undermine nursing professional practice. The success of policy compliance or effectiveness in relation to good patient outcomes and quality of care is difficult to measure, and this study highlights that easy-to-measure policy non-compliance related to adverse clinical events and incidents reflects a naive and underdeveloped view of this area of complexity and practice in healthcare. Further, the study challenges healthcare professionals and administrators to look towards complexity as a model of understanding and exploring more effective methods of measuring and evaluating good nursing practice.

For some time, nurses have faced a dilemma of how to deal with practice, and they believe there is a better solution than is stated in the policy. This study has positioned itself in the middle of a problem that proposes that rules in policy form are no longer self-evident and automatically enacted by nurses. Ultimately, healthcare has been moving into a more negotiated practice environment, and there is a need for more conversation and communication about nursing practice.

This study has made several recommendations and considered the implications for nursing practice. It has made a positive contribution to the knowledge in this area of study and provided directions for future research. This study arose from the researcher's need to understand how nurses can practice safely in providing care to their patients, and the challenge remains complex and never ending. This thesis closes with a quote from Florence Nightingale's book, *Notes on a Hospital*, which continues to be as aspirational today as it was in 1863. In this Year of the Nurse and Midwife, we celebrate Florence's 200th birthday and the contribution that she made to healthcare:

> "It may seem a strange principle to enunciate as the very first requirement in a Hospital is that it should do the sick no harm". (Nightingale, 1859, p. ii)

Appendix 1A: Participant Information Kit—Phase One

Research Kit

Making Sense of Hospital Policies –
A pilot study of lived experience of nurses and managers and the relationship between hospital policy and nursing practice

Includes:

1. Introductory Letter to Participant
2. Participant Information Sheet
3. Participant Consent Form

St Vincent's Health & Aged Care

9th August, 2011

Dear
I am currently completing my Doctor of Health Service Management at the University of New England. As part of this study, I am conducting a pilot research project – "Making sense of hospital policies – a pilot study of lived experience of nurses and managers and the relationship between hospital policy and nursing practice" under the supervision of Professor Steven Campbell, Associate Professor Godfrey Isouard and Dr David Briggs.
As you may be aware, in my role as Regional Safety & Quality Manager within St. Vincent's Health & Aged Care I am involved in the development, implementation and evaluation of hospital policies in collaboration with the facility Quality & Risk teams. The general aim is that hospital policies should assist managers and staff to ensure high and safe quality provision of care whilst also meeting the needs and experiences of a broad range of internal and external stakeholders. But hospitals are complex, dynamic and constantly in the midst of change processes, and whether or not evidence based practice and hospital policies can translate in nursing practice emphasises that the relationship between policy and practice is in constant tension. Nurses and managers are continuously engaged in a process of making sense of their environment, which drives their decision making that guides actions or nursing practice.
This pilot project aims to explore the lived experiences of nurses and managers and how they make sense of the relationship between hospital policy and nursing practice. I am particularly interested in those hospital policies that relate to safe clinical practice and affect patient care experiences.
As a result, I am writing to request your assistance in participating in this pilot project study. The research is potentially beneficial to the nursing and health manager community as it will be used to gain greater understanding of the lived experiences of sensemaking with nurses and managers in the hospital setting that impacts on the application of hospital policy into practice. This project will inform the development of a larger research study in this area for my Doctoral Thesis.
This pilot project will involve an individual interview with a total of 10 participants who are nurses and managers at St. Vincent's Hospital Toowoomba. In the attached kit I have provided a copy of the Participant Information Sheet and Participant Consent Form for your information. I will provide explanation and request that you sign the consent form prior to

participation in the interview. Please do not hesitate to contact me should you have any questions or concerns.

Kind Regards,

Christine Foley
Regional Safety & Quality Manager
St. Vincent's Health & Aged Care
M. 04
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TITLE OF RESEARCH PROJECT

Making sense of hospital policies – a pilot study of lived experience and the relationship between hospital policy and nursing practice

WHO IS CONDUCTING THIS RESEARCH

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My name is Christine Foley, I am the Researcher who will be conducting this research study under the supervision of Professor Steven Campbell, Associate Professor Godfrey Isouard and Dr David Briggs for fulfillment of research higher degree requirements in a Doctor of Health Services Management at the University of New England.

Researcher Reflective

As a researcher, it is important for me to disclose to all participants that I work in a senior role within St. Vincent's Health & Aged Care. I am a Registered Nurse employed full-time as the Regional Safety & Quality Manager within St. Vincent's Health & Aged Care, a catholic health and aged care provider operating in South East Queensland under the Governance of St. Vincent's Health Australia. The research project will involve the hospital services operating within St. Vincent's Health & Aged Care in Queensland.

I recognise that my role in the organisation may cause some concern among potential participants about what information they feel comfortable to openly provide, and how this information may be used that may affect them. It is important for me to raise this potential issue upfront and reassure all potential participants of my commitment to undertaking ethical research and adhere to a code of conduct, and to present my views and what I will do with any information provided to me. Firstly, the main reason for me undertaking this research is because of my own lived experiences as a patient, a Registered Nurse, a Ward and Executive Manager, and a Safety & Quality Manager at various times over the past 25 years. I have observed how many hospital policies exist, with varying forms of access to them, varying level of evidence basis, written by managers with varying levels of experience and understanding of their application, with limited implementation and evaluation processes, and where they can become the focus of regulators and judiciary when an adverse event is being reviewed or investigated. So many questions arise in my mind and from my experience – Is there a policy in place? If so, what does it say the nurse should have done? Did the nurse know about the policy? If not, why not? If so, then how did they come to know about it? Did the nurse follow the policy? If not, why not? If so, then why? Does the policy reflect the reality of the complexity and context of local clinical practice? What was the implementation process for the policy? Has the policy been regularly evaluated? There are

so many hospital policies for nurses to know about that are applicable to their day to day practice, and I wonder how anyone can really ever know about what is included in every hospital policy, and how does a casual or agency nurse know and understand what the local policies are and how to access them.

While various external bodies have an expectation or requirement that a number of hospital policies are implemented and evaluated to ensure patient safety and high quality care, my personal view and lived experience is that those expectations may be unrealistic and reflect a disconnect between the external expectations and requirements and the reality of what actually happens in local clinical practice, given the existing complexities, context, technology and workloads.
My role as a senior manager in St. Vincent's Health & Aged Care means that I am in an extremely fortunate position to talk to nurses and managers at the ward level to try to understand what is actually going on, and then to take this knowledge back up the line management tree to inform other senior managers of the day to day reality of clinical practice and assist in planning strategies than can more appropriately improve the relationship between the policies that we are required to implement and evaluate, and what we actually do that makes a real difference to nurses and patients for safer and higher quality care.
All information that I receive from staff will not contain any individually identifiable references to staff names, titles or ward locations. I have presented this research proposal to the St. Vincent's Health & Aged Care Regional Executive team in May 2011, including the Chief Executive Officer and General Managers, who have provided their support for the conduct of this research study.

WHAT ARE MY CONTACT DETAILS?

Christine Foley
Doctoral Student
Regional Safety & Quality Manager
St. Vincent's Health & Aged Care

Telephone: 07 3326 3733
Mobile: 04
Email: chris.foley@svhac.org.au
Address: 48 Montpelier Road, Bowen Hills. Qld. 4006

WHO ARE THE ORGANISATIONS INVOLVED IN THIS RESEARCH?

St. Vincent's Health & Aged Care
Regional Services & Support Office
48 Montpelier Road, Bowen Hills. Qld. 4006

St. Vincent's Hospital Toowoomba
Scott Street, East Toowoomba. Qld. 4350

WHY IS THIS RESEARCH BEING CONDUCTED?

Hospital policies are used to assist managers to ensure safe and high quality provision of care whilst meeting the needs and expectations of a broad range of internal and external stakeholders in a complex. Whether or not hospital policies can translate into local clinical practice emphasises that the relationship between policy and practice is in constant negotiation, with nurses continuously having to make sense of what is going on around themselves in order to make clinical decisions and provide care.
While evidence based health policy can be seen as the panacea of modern healthcare provision and an increasing expectation of key stakeholders, there is little written in the literature about local hospital policy implementation and evaluation despite the key part it plays in clinical governance systems.
This pilot study aims to explore the lived (or real life) experiences of nurses and managers and how they make sense of the impact of hospital policy on nursing practice within a safety and quality framework. The results of this research will be used to gain greater understanding of the lived experiences with nurses and managers making sense of day to day practice in the hospital setting that impacts on the application of hospital policy and nursing practice. The study will provide information to assist in the identification of the

broader research problem of the contested terrain between hospital policy and nursing practice that is sought to be clarified and the research approach further developed around the specific areas of experience in relation to theory and practice for a larger study of my Doctoral Thesis.

HOW ARE PARTICIPANTS BEING SELECTED?

You have been asked to participate in the study in order to assist the Investigator to gain a rich understanding of your experiences of the relationship between hospital policy and nursing practice. I will be seeking participation of the General Manager, Director of Clinical Services, Quality & Risk team for interviews and negotiate other nurses and managers to approach to participate in the study. There will be a total of 10 participants included in this pilot study.

WHAT WOULD YOU BE ASKED TO DO AS A PARTICIPANT?

Participants will be invited to meet with the Investigator for a face to face meeting for approximately one hour in order to undertake an interview where you will be asked to respond to a few open ended questions about your personal experiences with hospital policies and nursing practice. Each interview will be audio taped, only the Investigator will have access to the audio tape to transcribe the interview verbatim into text and summarise key themes that will be provided back to the participant in order to check the descriptive interpretation and clarify if there is any omitted or new information.

WHAT ARE THE EXPECTED BENEFITS?

It is anticipated that the findings of this research will result in gaining a greater understanding of the lived experiences of nurses and managers in the hospital setting, how they make sense of hospital policies and then how that impacts on the application of hospital policies to nursing practice on a day to day basis. The pilot study will inform the direction of a larger study that will be undertaken in relation to hospital policies and nursing practice.

CONSENT TO PARTICIPATE

Participation in this research project is entirely voluntary and participants are not under any obligation to consent to participate in the project. Your decision whether to participate in the research or not will not affect any existing relationship that you have with St. Vincent's Hospital Toowoomba, St. Vincent's Health & Aged Care or the University of New England.

ARE THERE ANY RISKS TO YOU?

I do not anticipate any risks to any participant as a result of his/her participation in this research project as the participant's are asked to only reveal during interviews / focus groups what they feel comfortable stating. If during the interview / focus group any participants feel uncomfortable the Investigator will stop the session to five the participant time to consider whether they wish to continue. No content generated from any interviews will be used against participants by managers or in relation to performance issues. If participants feel that they need to talk with someone further about any issues raised, the Investigator will provide the details of an appropriate contact person for ongoing discussion.

HOW WILL YOUR CONFIDENTIALITY BE MANAGED?

Any computer files or documents arising from this research project will not contain any identifying data and confidentiality will also continue to be maintained during and after completion of the project. The data collected from this project will be reported in general terms and will not involve any identifying names. All data collected will be stored in a locked cabinet within Executive Services at the St. Vincent's Health & Aged Care Regional Services & Support Office during the project and for the next 7 years before being destroyed.

HOW WILL YOU GET FEEDBACK ON THE RESULTS?

A summary of themes from the transcribed interview will be provided to each participant to check interpretation of descriptive information, identify any information omitted or any new information. A copy of the interview transcript and report on the general findings from the research project will be made available to participants if requested.

VOLUNTARY PARTICIPATION

Your participation in this research project is voluntary. If you wish, you can withdraw you participation in this project at any time without explaining a reason. Your decision to withdraw will not affect any existing relationship that you have with St. Vincent's Hospital Toowoomba, St. Vincent's Health & Aged Care or the University of New England.

ETHICAL CONDUCT

St. Vincent's & Health & Aged Care and the University of New England conduct research in

accordance with the National Statement on Ethical Conduct in Research Involving Humans. This pilot research project has been approved for expedited review by the St. Vincent's Health & Aged Care Human Research and Ethics Committee Chairperson in August 2011.

If participants should have any concerns or complaints about the ethical conduct of the research project they should contact:

Chairperson
Human Research & Ethics Committee
St. Vincent's Health & Aged Care
48 Montpelier Road, Bowen Hills. Qld. 4006
Telephone: 07 3326 3739

PRIVACY STATEMENT

The conduct of this research involves the collection, access and / or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will be safeguarded at all times. For further information you may consult the University of New England's Privacy Policy and St. Vincent's Health & Aged Care Privacy Policy.

WHO CAN YOU TALK TO IF YOU WANT MORE INFORMATION?

For any further information please do not hesitate to contact the Investigator:

Christine Foley
Doctoral Student
Regional Safety & Quality Manager
St. Vincent's Health & Aged Care

Thank you for your participation in this research study.

Consent form for Participants

TITLE OF RESEARCH PROJECT

Making sense of hospital policies – a pilot study of lived experience and the relationship between hospital policy and nursing practice

INVESTIGATORS:

Professor Steven Campbell
(Principal Supervisor)
Head of School
School of Health
Faculty of the Professions
University of New England

Associate Professor Godfrey Isouard
(Co-Supervisor)
School of Health
University of New England

Dr David Briggs
(Co-Supervisor)
School of Health
University of New England

Christine Foley
Doctoral Student
School of Health
University of New England

I have read the Information Sheet for Participants and understand that:

- The research aims to explore the lived (real life) experience of nurses and managers and how they make sense of the impact of hospital policy on local clinical practice within a safety & quality framework.

- The study seeks out general inquiry of lived experience across a range of participant perspectives internal and external to the organisation and then to provide particular inquiry through a participant driven case study of existing hospital policies within St. Vincent's Health & Aged Care hospitals.
- I will be asked to participate in a semi-structured in-depth interview in order to gather information about my experiences with hospital policies and their relationship with day to day clinical practice.
- The interview will be audio taped then transcribed verbatim by the Investigator and a summary of themed information provided to me to check the interpretation of information and any omitted or new information.
- I understand that my participation is voluntary and I can withdraw my participation at any time without giving a reason or be penalised.
- I understand that I will experience no loss or benefit in my interactions with the organisation or the University if I withdraw my participation.
- I understand that any reports or publication resulting from this study will be reported in general terms and will not involve any features that might identify my contribution.
- I understand that the information generated from my participation may be used in further studies related to this research area for the Investigator's Doctoral Thesis and will remain non-identifiable and will not involve any features that might identify my contribution.

I understand that the data generated from this research project will be kept confidential at all times and stored in a locked cabinet in the Executive Services area of the Regional • Services & Support Office of St. Vincent's Health & Aged Care for a period of 5 years before being destroyed.

- A report on the research findings will be made available to me on completion of the project at my request.
- I understand that I can contact the Investigator on the contact details provided to me on the Information Sheet for Participants, and I can contact the Chairman of the HREC at St. Vincent's Health & Aged Care (Telephone: 07 3326 3739) should I have any concerns about the ethical conduct of the project.
- I have read the Information Sheet for Participants and the Consent Form.
- I agree to participate in this research project and given my Consent freely.
- I understand that the research project will be carried out as described in the Information Sheet for Participants, a copy of which I have retained.
- I understand that it is my decision whether or not I participate and my decision will not affect my association with the Investigators, St. Vincent's Hospital Toowoomba, St. Vincent's Health and Aged Care or the University of New England in any way.
- I understand that I can withdraw my consent for participation in the research project at any time and that I do not have to provide any reason for my withdrawal.

- I have had all questions about the research project answered by the Investigator to my satisfaction.

Name of Participant:.....

Signature of Participant:..... Date: .....

Appendix 1B: Participant Information Kit—Phase Two

ST VINCENT'S HEALTH AUSTRALIA

UNIVERSITY OF TECHNOLOGY SYDNEY

22nd May, 2013

Dear Sir / Madam,

I am currently completing a Doctor of Philosophy award from the University of Technology Sydney (UTS). As part of this program, I am conducting a research study titled "An ethnographic approach to making sense of the relationship between policy and nursing practice" under the supervision of Professor Rick Iedema and Dr Suyin Hor, from the Centre for Health Communication at UTS.

In my usual role as Regional Safety & Quality Manager within St. Vincent's Health Australia in collaboration with The Holy Spirit Northside Private Hospital, I am involved in the development, implementation and evaluation of hospital policies in collaboration with the facility Quality & Risk teams in the Queensland region. The general aim is that hospital policies should assist managers and staff to ensure high and safe quality provision of care. But hospitals are complex and constantly dealing with change, which makes knowing and understanding every policy difficult for nurses at the bedside.

This study aims to work collaboratively with participants to explore their experiences and perspectives of how they make sense of the relationship between policy and nursing practice. I am particularly interested in those hospital policies that relate to safe clinical practice and affect patient care experiences, such as patient falls prevention and management policy and related nursing practices.

I am writing to request your assistance in participating in this study. The research can benefit the nursing and the broader community as it will be used to gain greater understanding of the experiences and perspectives of nurses, patients, managers and external stakeholders that impacts how we put policy into nursing practice.

This study will involve me, the researcher, working with a local ward nurse in a ward in three hospitals for up to a week, making observations of the nursing work, it's complexity and how it relates to policy and practice. Nurses, patients, managers and other stakeholders will be identified as potential participants to seek consent for interviews with audio or video recording where appropriate.

In the attached kit I have provided a copy of the Participant Information Sheet and Participant Consent Form for your information. I will be happy to answer any of your questions and request that you sign the consent form prior to participation. Please do not hesitate to contact me should you have any questions or concerns.

Kind Regards,

Christine Foley
Regional Safety & Quality Manager
M. 04[redacted]
E. chris.foley@svhac.org.au

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ST VINCENT'S HEALTH AUSTRALIA

UNIVERSITY OF TECHNOLOGY SYDNEY

Participant Information Sheet

TITLE OF RESEARCH PROJECT

An ethnographic approach to making sense of the relationship between policy and nursing practice

WHO IS CONDUCTING THIS RESEARCH?

My name is Christine Foley, I am the Researcher who will be conducting this research study under the supervision of Professor Rick Iedema and Dr Suyin Hor (Centre for Health Communication) for fulfillment of research higher degree requirements in a Doctor of Philosophy award at the University of Technology Sydney.

WHAT ARE MY CONTACT DETAILS?

Christine Foley
Doctoral Student
Regional Safety & Quality Manager
Queensland Region
St. Vincent's Health Australia

Telephone: 07 3326 3733
Mobile: 0[redacted]
Email: chris.foley@svhac.org.au
Address: 48 Montpelier Road, Bowen Hills. Qld. 4006

WHO ARE THE ORGANISATIONS INVOLVED IN THIS RESEARCH?

1. St. Vincent's Hospital Toowoomba
Scott Street, East Toowoomba. Qld.

2. St. Vincent's Hospital Brisbane
Main Street, Kangaroo Point. Qld

3. Holy Spirit Northside Private Hospital
Rode Road, Chermside. Qld

WHY IS THIS RESEARCH BEING CONDUCTED?

Hospital policies are used to assist managers to ensure safe and high quality provision of care in a complex environment. The study aims to explore, understand and describe the complexity that nurses work involves on a day to day basis, and the relationship between policy and nursing practice – what works, what doesn't work, what needs to happen to make the policy add value to nurses work and patient experiences.

Should you wish to read any more detail about why the research is being conducted, you can refer to the "Researcher Reflective" attached at the end of this kit. This is simply a summary of my experience and reasons for raising the research question and wanting to do something about a problem that I have identified.

HOW ARE PARTICIPANTS BEING SELECTED?

You have been asked to participate in the study in order to assist me as the researcher to gain an understanding of your experiences and perspectives of the relationship between hospital policy and nursing practice. I will be seeking participation from local ward nurses, patients and their families, managers in consultation with the Nurse Unit Manager on the ward and Directors of Clinical Services, and external stakeholders identified as playing a key role in the policy and practice area.

WHAT WOULD YOU BE ASKED TO DO AS A PARTICIPANT?

Participants will be invited to meet with the researcher for a face to face meeting for 10 minutes up to one hour (depending on your availability) in order to undertake an interview where you will be asked to respond to a up to six open ended questions about your experiences and perspectives with policies and nursing practice. Each interview will be audio or video taped based on your agreement, only the researcher will have access to the audio or video file to transcribe the interview into text and identify key themes that will be provided back to the participant in order to check the descriptive interpretation and clarify if there is any omitted or new information. This means that only you get to see or read the summary of your information provided, which will not be identified for the final report with your name or other identifying data.

WHAT ARE THE EXPECTED BENEFITS?

It is anticipated that the findings of this research will result in gaining a greater understanding of the experiences and perceptions of nurses, patients and their families, managers and external stakeholders, how they make sense of policies and then how that impacts on the application of hospital policies to nursing practice on a day to day basis.

CONSENT TO PARTICIPATE

Participation in this research project is entirely voluntary and participants are not under any obligation to consent to participate in the project. Your decision whether to participate in the research or not will not affect any existing relationship that you have with the hospital, St. Vincent's Health Australia and The Holy Spirit Northside Private Hospital or the University of Technology Sydney.

ARE THERE ANY RISKS TO YOU?

I do not anticipate any risks to any participant as a result of his/her participation in this research project as the participants are asked to only reveal during observation or interviews what they feel comfortable stating. If during the observation or interview any participants feel uncomfortable the researcher will stop the session to give the participant time to consider whether they wish to continue. No content generated from any observation or interviews will be used against participants by managers or in relation to performance issues. If participants feel that they need to talk with someone further about any issues raised, the researcher will provide the details of an appropriate contact person for ongoing discussion.

HOW WILL YOUR CONFIDENTIALITY BE MANAGED?

Any computer files or documents arising from this research study will not contain any identifying data and confidentiality will also continue to be maintained during and after completion of the study. The data collected from this study will be reported in general terms and will not involve any identifying names. All data collected will be stored in a locked cabinet within a locked room in Executive Services at the St. Vincent's Health Australia Queensland Region - Regional Services & Support Office during the project and for the next 7 years before being destroyed.

HOW WILL YOU GET FEEDBACK ON THE RESULTS?

A summary of themes from the transcribed interview and relevant observations will be provided to each participant to check interpretation of descriptive information, identify any information omitted or any new information. A copy of the interview transcript and report on the general findings from the research study will be made available to participants if requested.

VOLUNTARY PARTICIPATION

Your participation in this research project is voluntary. If you wish, you can withdraw your participation in this project at any time without explaining a reason. Your decision to withdraw will not affect any existing relationship that you have with the hospital, St. Vincent's Health Australia, The Holy Spirit Northside Private Hospital or the University of Technology Sydney.

ETHICAL CONDUCT

St. Vincent's & Health Australia, the Holy Spirit Northside Private Hospital and the University of Technology Sydney conduct research in accordance with the National Statement on Ethical Conduct in Research Involving Humans. This research study has been submitted for approval by the St. Vincent's Health & Aged Care (Queensland Region) Human Research and Ethics Committee in May 2013.

If you should have any concerns or complaints about the ethical conduct of the research study you can contact:

Chairperson
Human Research & Ethics Committee
St. Vincent's Health & Aged Care
Queensland Region
48 Montpelier Road, Bowen Hills. Qld. 4006
Telephone: 07 3326 3739

PRIVACY STATEMENT

The conduct of this research involves the collection, access and / or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A non-identifiable copy of this data may be used for other research purposes. However, your anonymity will be safeguarded at all times. For further information you may consult the University of Technology Sydney's Privacy Policy and St. Vincent's Health & Aged Care Privacy Policy.

WHO CAN YOU TALK TO IF YOU WANT MORE INFORMATION?

For any further information please do not hesitate to contact the Investigator:

Christine Foley
Doctoral Candidate (Researcher)
Regional Safety & Quality Manager
Queensland Region
St. Vincent's Health Australia

Telephone: 07 3326 3733
Mobile: 04[redacted]
Email: chris.foley@svhac.org.au
Address: 48 Montpelier Road, Bowen Hills. Qld. 4006

Thank you for your participation in this research study, your cooperation is greatly appreciated in contributing to improving patient safety and care experience.

ST VINCENT'S HEALTH AUSTRALIA

UNIVERSITY OF TECHNOLOGY SYDNEY

Consent Form for Participants

TITLE OF RESEARCH PROJECT

An ethnographic approach to making sense of the relationship between policy and nursing practice

I have read the Information Sheet for Participants and understand that:

- The research aims to explore, understand and describe the complexity that nurses work involves on a day to day basis, and the relationship between policy and nursing practice – what works, what doesn't work, what needs to happen to make the policy add value to nurses work and patient experiences.
- For nurses and patients, I may be observed in by the researcher in the day to day nursing work undertaken in the ward setting, and the researcher may make field notes about observations that does not identify who I am.
- I may be asked to participate in an interview in order to gather information about my experiences and perspectives with hospital policies and their relationship with day to day clinical practice.
- The interview will be audio and /or video taped then transcribed verbatim by the researcher and a summary of themed information provided back to me to check the interpretation of information and any omitted or new information.
- I understand that my participation is voluntary and I can withdraw my participation at any time without giving a reason and I understand that I will not be disadvantaged in any way for making this decision.
- I understand that I will experience no loss or benefit in my interactions with the organisation or the University if I withdraw my participation.
- I understand that any reports or publication resulting from this study will be reported in general terms and will not involve any features that might identify my contribution.
- I understand that the information generated from my participation may be used in further studies related to this research area that receives HREC approval for the researcher's Doctoral Thesis and will remain non-identifiable and will not involve any features that might identify my contribution.
- I understand that the data generated from this research study will be kept confidential at all times and stored in a locked cabinet in a locked room within the Executive Services area of the Regional Services & Support Office of St. Vincent's Health & Aged Care (Queensland Region of St. Vincent's Health Australia) for a period of 7 years before being destroyed.
- A report on the research findings will be made available to me on completion of the study at my request.

- I understand that I can contact the researcher on the contact details provided to me on the Information Sheet for Participants, and I can contact the Chairman of the HREC at St. Vincent's Health & Aged Care (Telephone: 07 3326 3739) should I have any concerns about the ethical conduct of the project.
- I have read the Information Sheet for Participants and the Consent Form.
- I agree to participate in this research study and given my Consent freely.
- I understand that the research study will be carried out as described in the Information Sheet for Participants, a copy of which I have retained.
- I understand that it is my decision whether or not I participate and my decision will not affect my association with the researchers, St. Vincent's Health Australia, the Holy Spirit Northside Private Hospital or the University of Technology Sydney in any way.
- I understand that I can withdraw my consent for participation in the research study at any time and that I do not have to provide any reason for my withdrawal.
- I have had all questions about the research study answered by the researcher to my satisfaction.

Name of Participant:.....

Signature of Participant:..... Date: .....

ST VINCENT'S HEALTH AUSTRALIA

UNIVERSITY OF TECHNOLOGY SYDNEY

Researcher Reflective

(Why is the research being conducted?)

As a researcher, it is important for me to disclose to all participants that I work in a senior role within St. Vincent's Health & Aged Care. I am a Registered Nurse employed full-time as the Regional Safety & Quality Manager within St. Vincent's Health & Aged Care, a catholic health and aged care provider operating in South East Queensland under the Governance of St. Vincent's Health Australia. The research project will involve three hospitals operating within St. Vincent's Health & Aged Care in Queensland.

I recognise that my role in the organisation may cause some concern among potential participants about what information they feel comfortable to openly provide, and how this information may be used that may affect them. It is important for me to raise this potential issue upfront and reassure all potential participants of my commitment to undertaking ethical research and adhere to a code of conduct, and to present my views and what I will do with any information provided to me. Firstly, the main reason for me undertaking this research is because of my own lived experiences as a patient, a Registered Nurse, a Ward and Executive Manager, and a Safety & Quality Manager at various times over the past 25 years. I have observed how many hospital policies exist, with varying forms of access to them, varying level of evidence basis, written by managers with varying levels of experience and understanding of their application, with limited implementation and evaluation processes, and where they can become the focus of regulators and judiciary when an adverse event is being reviewed or investigated. So many questions arise in my mind and from my experience – Is there a policy in place? If so, what does it say the nurse should have done? Did the nurse know about the policy? If not, why not? If so, then how did they come to know about it? Did the nurse follow the policy? If not, why not? If so, then why? Does the policy reflect the reality of the complexity and context of local clinical practice? What was the implementation process for the policy? Has the policy been regularly evaluated? There are so many hospital policies for nurses to know about that are applicable to their day to day practice, and I wonder how anyone can really ever know about what is included in every hospital policy, and how does a casual or agency nurse know and understand what the local policies are and how to access them.

While various external bodies have an expectation or requirement that a number of hospital policies are implemented and evaluated to ensure patient safety and high quality care, my personal view and lived experience is that those expectations may be unrealistic and reflect a disconnect between the external expectations and requirements and the reality of what actually happens in local clinical practice, given the existing complexities, context, technology and workloads.

My role as a senior manager in St. Vincent's Health & Aged Care means that I am in an extremely fortunate position to talk to nurses and managers at the ward level to try to understand what is actually going on, and then to take this knowledge back up the line management tree to inform other senior managers of the day to day reality of clinical practice and assist in planning strategies than can more appropriately improve the relationship between the policies that we are required to implement and evaluate, and what we actually do that makes a real difference to nurses and patients for safer and higher quality care.

All information that I receive from participants will not contain any individually identifiable references to names, titles, organisations or locations. I have presented a summary of the research proposal to the Directors of Clinical Services in the three hospitals, who have provided their support for the conduct of this research study.

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Appendix 2A: Human Research and Ethics Approvals—Phase One

St Vincent's Health & Aged Care

12 August 2011

Ms Christine Foley
Regional Safety & Quality Manager
St Vincent's Health & Aged Care
48 Montpelier Road
BOWEN HILLS QLD 4006

Dear Ms Foley

Re: Making sense of hospital policies – a pilot study of lived experience and the relationship between hospital policy and nursing practice (HREC #11/09)

Thank you for your correspondence of 8 August 2011 submitting the following documents for consideration:

- NEAF
- Research Proposal
- Participant Recruitment Letter
- Participant Information Sheet
- Participant Consent Form

According to Chapter 2.1 of the National Statement on Ethical Conduct in Human Research which identifies guidelines to address negligible risk research (clause 2.1.7), I have assessed the criteria and am pleased to **grant approval** of this pilot study by expedited review.

With best wishes for the success of the project.

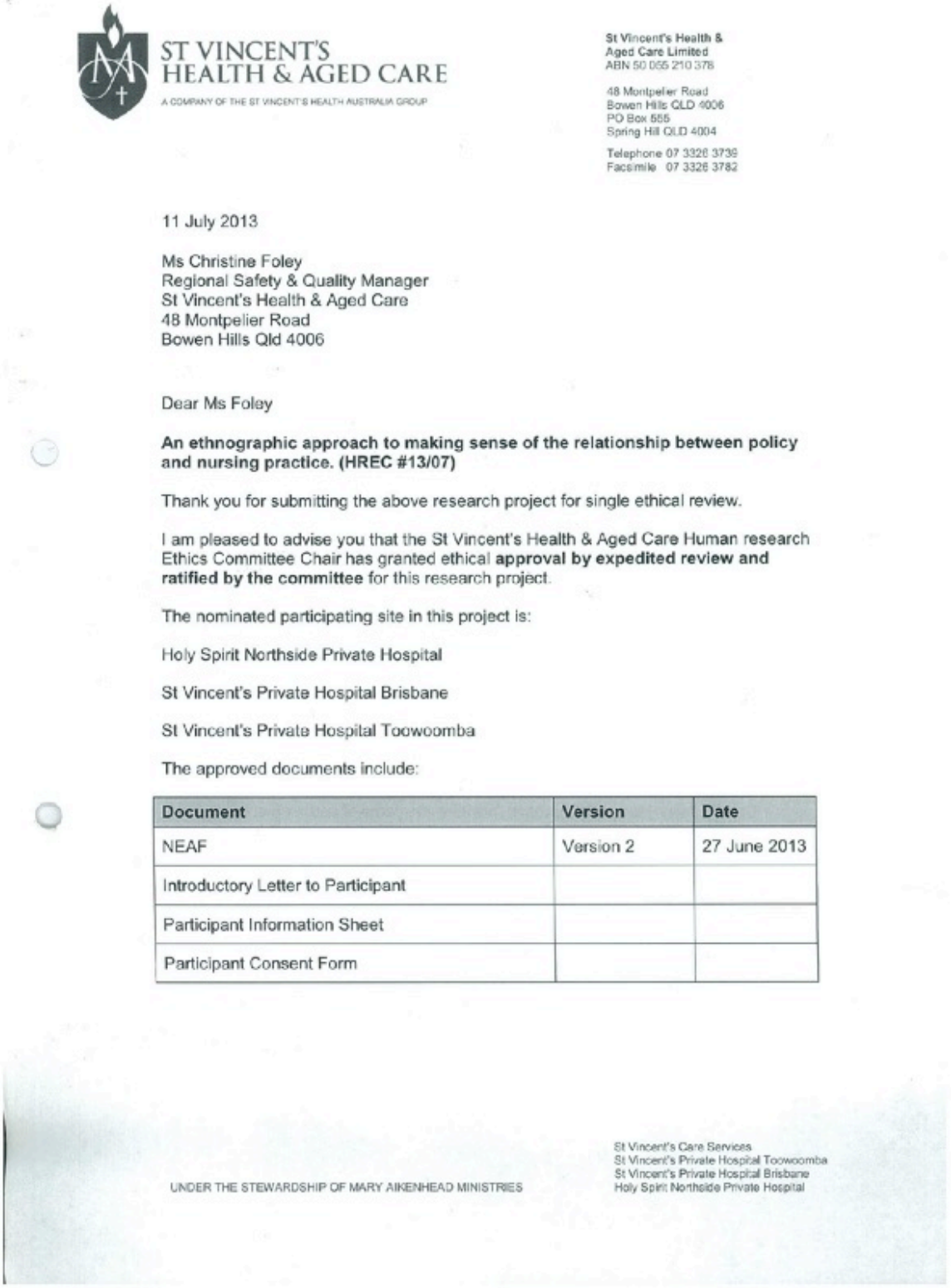
Yours sincerely

Carl Yuile
Chair
Human Research Ethics Committee

St Vincent's Health & Aged Care Ltd ABN 50 055 210 378
48 Montpelier Road, Bowen Hills Qld 4006 PO Box 555, Spring Hill Qld 4004
T: 07 3326 3739 F: 07 3326 3782
E: info@svhac.org.au W: www.svhac.org.au

MARY AIKENHEAD MINISTRIES

Appendix 2B: Human Research and Ethics Approvals—Phase Two



ST VINCENT'S HEALTH & AGED CARE
A COMPANY OF THE ST VINCENT'S HEALTH AUSTRALIA GROUP

St Vincent's Health &
Aged Care Limited
ABN 50 055 210 378

48 Montpelier Road
Bowen Hills QLD 4006
PO Box 555
Spring Hill QLD 4004

Telephone 07 3326 3739
Facsimile 07 3326 3782

11 July 2013

Ms Christine Foley
Regional Safety & Quality Manager
St Vincent's Health & Aged Care
48 Montpelier Road
Bowen Hills Qld 4006

Dear Ms Foley

An ethnographic approach to making sense of the relationship between policy and nursing practice. (HREC #13/07)

Thank you for submitting the above research project for single ethical review.

I am pleased to advise you that the St Vincent's Health & Aged Care Human research Ethics Committee Chair has granted ethical **approval by expedited review and ratified by the committee** for this research project.

The nominated participating site in this project is:

Holy Spirit Northside Private Hospital

St Vincent's Private Hospital Brisbane

St Vincent's Private Hospital Toowoomba

The approved documents include:

Document	Version	Date
NEAF	Version 2	27 June 2013
Introductory Letter to Participant		
Participant Information Sheet		
Participant Consent Form		

Approval of this project from St Vincent's Health & Aged Care Human Research Ethics Committee is valid from 11 July 2013 subject to the following conditions being met:

- The Coordinating Principal Investigator will immediately report anything that might warrant review of ethical approval of the project.

- The Coordinating Principal Investigator will notify the St Vincent's Health & Aged Care Human Research Ethics Committee of any event that requires a modification to the protocol or other project documents and submit any required amendments in accordance with the instructions provided by the HREC.

- The Coordinating Principal Investigator will submit any necessary reports related to the safety of research participants in accordance with St Vincent's Health & Aged Care Human Research Ethics Committee policy and procedures.

- The Coordinating Principal Investigator will report to the St Vincent's Health & Aged Care Human Research Ethics Committee annually in the specified format and notify the HREC when the project is completed at all sites.

- The Coordinating Principal Investigator will report to the St Vincent's Health & Aged Care Human Research Ethics Committee quarterly; the numbers of participants currently involved in the research study and identify the sites participants are attending for the research study.

- The Coordinating Principal Investigator will notify the St Vincent's Health & Aged Care Human Research Ethics Committee if the project is discontinued at a participating site before the expected completion date, with reasons provided.

- The Coordinating Principal Investigator will notify the St Vincent's Health & Aged Care Human Research Ethics Committee of any plan to extend the duration of the project past the approval period listed above and will submit any associated required documentation.

- The Coordinating Principal Investigator will notify the St Vincent's Health & Aged Care Human Research ethics Committee of his or her inability to continue as Coordinating Principal Investigator including the name of and contact information for a replacement.

Can I please request that you provide the details of the nominated party responsible for payment to the HREC. On receipt of this information a tax invoice will be issued to this party.

Should you have any queries about the St Vincent's Health & Aged Care Human Research Ethics Committee consideration of your project please contact Rachel Jagodzinski, HREC Executive Secretary on 07 3326 3749 or Rachel.jagodzinski@svhac.org.au.

The St Vincent's Health & Aged Care Human Research Ethics Committee wishes you every success in your research.

Yours faithfully,

Mary Dalmau
Acting Chair
SVHAC HREC

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*.

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